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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARY Elizabeth Freed</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>31</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>5:55 P M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>214-12-8399</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9/23/04</b>                                       |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>BALTIMORE COUNTY GENERAL HOSPITAL</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Randallstown</b>                                  |   |
| 9c. COUNTY OF DEATH<br><b>Balto</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore</b>   |   |
| 10c. CITY, TOWN OR LOCATION<br><b>Randallstown</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>3806 Fernside Road</b>   |   |
| 10f. ZIP CODE<br><b>21133</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Unknown</b><br>College (1-4 or 5+) <b></b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Basil Johnson</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Emma Williams</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Vivian Hare</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3741 Trent Road Randallstown, MD 21133</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Parkville, MD</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Stephen M. Jenkins</i>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Road Randallstown, MD 21133</b>   |  |   |  |   |   |
| 23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CARDIO Respiratory arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>b. PERIPHERAL vasc. disease / GANGRENE @ Foot</b><br><b>c. Diabetes mellitus</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Ram Nimmagadda MD</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>BD 36612</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/31/90</b>                                       |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Phone</i>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 2 - 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21207-3100

DIVISION OF VITAL RECORDS, P.O. BOX 1314

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use as a burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Ralph Waldo Forder   |  |  |  | 2. DATE OF DEATH<br>MONTH 4 DAY 01 YEAR 90  |  | 3. TIME OF DEATH<br>10:50 P. M.   |  |
| 4. SOCIAL SECURITY NUMBER<br>216-09-9176   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>95 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>3/30/1895  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Baptist Home of Maryland   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Owings Mills   |  | 9c. COUNTY OF DEATH<br>Baltimore  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Baltimore   |  | 10c. CITY, TOWN OR LOCATION<br>Owings Mills   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>Baptist Home of MD Park Heights Ave. 10729   |  |  |  | 10f. ZIP CODE<br>21117  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (8-12) Unknown  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Martins   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John Forder   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mamie Montgomery   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mr. Ralph Winter Forder  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9051 Allenswood Road Randallstown, MD 21133  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Winters Cemetery   |  | 20c. LOCATION — City or Town, State<br>New Windsor, MD  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Loring Byers Funeral Directors Inc.   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Loring Byers Funeral Home<br>8728 Liberty Road Randallstown, MD 21133   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. SEVERE / PROGRESSIVE DEMENTIA<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. ALZHEIMER'S DISEASE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br>YEARS  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
|  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>John A. Forder MD   |  | 29c. LICENSE NUMBER<br>D20795   |  | 29d. DATE SIGNED (Month, Day, Year)<br>4-2-90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 2 - 1990  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1, 2, 3 should be retained by the hospital or attending physician. Pages 4, 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOHN WILSON FAIDLEY</b>  |  | 2. DATE OF DEATH<br><b>MARCH 31, 1990</b> YEAR  |   | 3. TIME OF DEATH<br><b>1:55pm</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-10-4633</b>   | 5. SEX<br><b>MALE</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN.  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>3-10-13</b>   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Agnes Hospital</b>   |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |   | 9c. COUNTY OF DEATH  |
| RESIDENCE OF DECEDENT   |  |   |   |   |  |
| 10a. STATE<br><b>Maryland</b>   | 10b. COUNTY<br><b>Baltimore</b>  | 10c. CITY, TOWN OR LOCATION<br><b>Catonsville</b>   |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>407 Forest Lane</b>  |  |   | 10f. ZIP CODE<br><b>21228</b>   |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>9th grade</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Seaford Business</b>        |   | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Self Emp.</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John W. Faidley</b>   |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Flossie Mae Dickey</b>  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Albina F. Faidley</b>  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>407 Forest Lane Baltimore, Maryland 21228</b>   |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery</b>   |   | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |   | 22. NAME AND ADDRESS OF FACILITY<br><b>Hubbard Funeral Home, Inc.</b><br><b>4107 Wilkens Ave. Baltimore, Md. 21229</b>  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CHF/Pulmonary Edema</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><div style="display: flex; align-items: center;"> <div style="font-size: 3em; margin-right: 10px;">{</div> <div> <b>Recurrent Myocardial ischemia</b><br/> <b>Atherosclerosis</b><br/> <b>Diabetes Mellitus</b> </div> </div> |  |   |   |   | Approximate Interval Between Onset and Death<br><b>16 days</b><br><b>YEARS</b><br><b>YEARS</b><br><b>YEARS</b>                                     |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CRF, COPD, Acute renal failure secondary to CHF, MI, lung CA (partial pneumectomy), D.M., Aortic stenosis</b>  |  |   |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |   |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |   |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |   | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |   | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>RALPH ALWALEL, MD</b>   |  |   | 29c. LICENSE NUMBER   |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/31/90</b>  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>900 Catow Ave Baltimore Md 21093</b>  |  |   |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 2, 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br>   |   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the page may be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROSE GLOYD FINNEYFROCK</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>March</b> DAY <b>28</b> , 1990 YEAR  |  |   |  | 3. TIME OF DEATH<br><b>11<sup>12</sup> A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-34-7048</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>53</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JULY 30, 1936</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>   |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>167A WATKINS MILL ROAD</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>GAITHERSBURG</b>  |  |
| 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |  |   |  | 10a. STATE<br><b>MD.</b>  |  |   |  | 10b. COUNTY<br><b>MONTGOMERY</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>GAITHERSBURG</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>167A WATKINS MILL ROAD</b>   |  |   |  | 10f. ZIP CODE<br><b>20879</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>—</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>MANAGEMENT</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>AUTOMOTIVE</b>   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>BERNARD GLOYD</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ESTELLE BAKER</b>   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>TINA FINNEYFROCK GOLDSTEIN</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>RT. #2 Box 104A EARLVILLE, NEW YORK 13332</b>   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ST. ROSE OF LIMA</b>   |  | 20c. LOCATION — City or Town, State<br><b>GAITHERSBURG, MD.</b>   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Muriel H. Barber</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MURIEL H. BARBER FUNERAL HOME<br/>21525 LAYTONSVILLE ROAD LAYTONSVILLE, MD. 20882</b>  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Cardiorespiratory arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <b>Stage IV Lymphoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
|   |  |   |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Sophia Untiveros</i><br><b>Sophia Untiveros</b>   |  | 29c. LICENSE NUMBER<br><b>D 29365</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/28/90</b>                                       |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)<br><b>8903 Shady Grove Court Gaithersburg, MD 20877</b>   |  |   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 2 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia...</i>  |  |   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 of this certificate is to be completed by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Joseph Calvin Gray Sr.  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3 24 90  |  | 3. TIME OF DEATH<br>11:20 AM   |  |
| 4. SOCIAL SECURITY NUMBER<br>216-22-4677  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>59 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Aug. 18, 1930                                   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  |  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Mercy Hospital  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City  |  | 9c. COUNTY OF DEATH<br>-----   |  |
| 10a. STATE<br>Md.   |  |  |  | 10b. COUNTY<br>-----   |  | 10c. CITY, TOWN OR LOCATION<br>Balto. City, Md.  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |  |  |
| 10e. STREET AND NUMBER<br>1327 S. Charles St.   |  |  |  | 10f. ZIP CODE<br>21230   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                    |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>8th. Grade  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Maintainence   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>-----  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Albert H. Gray, Sr.  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Ribella --- Brocato   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Joan A. Gray  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>809 Pontiac Ave. Balto. Md. 21225   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Metro Crematory, Inc.  |  | 20c. LOCATION — City or Town, State<br>Co. Catonsville, Balto.   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Shane Savage   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Balto. Md. 21230<br>McCully Funeral Home, 130 E. Fort Ave.   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  | Approximate interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
|   |  |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>XX YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>XXX Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)   |  |
| 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>for  |  |  |  | 29c. LICENSE NUMBER<br>OCME  |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-25-90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Julia C. Goodin, M.D., Assistant 111 Penn Street, Baltimore, MD 21201 vl   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 2 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DORTHEA JESSIE GAINFORT</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>03</b> DAY <b>29</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>5:55</b> a <input type="checkbox"/> m <input checked="" type="checkbox"/>               |  |
| 4. SOCIAL SECURITY NUMBER<br><b>231-26-4834</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 10, 1920</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Greater Baltimore Medical Center</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>  |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Towson</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO            |  |
| 10e. STREET AND NUMBER<br><b>108-4B Kenilworth Park Dr.</b>   |  |  |  | 10f. ZIP CODE<br><b>21204</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                     |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Case Worker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Dept. of Social Services</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James Gainfort</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Dorothea Lapp</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Arthur W. Arline</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as #10</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Greenmount Cemetery 3/31/90</b>  |  | 20c. LOCATION — City or Town, State<br><b>Balto., Md.</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Ronald E. Hays</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Rd., Towson, Md. 21204</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |  |  |   |  |  |  |
| a. <b>Pneumonia with gram positive &amp; negative sepsis</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| b. <b>Myeloproliferative disorder</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| c. <b>Focal right lower lung lobe infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| d. _____  |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Howard L. Siegel</i><br>M.D.  |  |  |  | 29c. LICENSE NUMBER<br><b>D28885</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/29/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Howard L. Siegel, M.D. - GBMC - 6701 N. Charles Street; Towson, MD 21204</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 2 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. ...</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Edith E. Hobbs   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3 29 90   |  | 3. TIME OF DEATH<br>1:00 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>220-18-5740   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>68 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>5/9/21  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Sinai Hospital  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore                                     |  |
| 9c. COUNTY OF DEATH  |  |  |  | 10a. STATE<br>MD  |  | 10b. COUNTY  |  |
| 10c. CITY, TOWN OR LOCATION<br>Baltimore   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 10e. STREET AND NUMBER<br>130 North Curley Street  |  |  |  | 10f. ZIP CODE<br>21224  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>white                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>unknown   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>domestic  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>housekeeping  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>James Walter Brooks   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Theresa Maquire  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Theresa I. Fallows   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2322 Harcroft Road/Timonium MD 21093   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Lorraine Park Cemetery   |  | 20c. LOCATION — City or Town, State<br>Baltimore, MD  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert S. Hobbs</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Moran-Ashton Funeral Home, Inc.<br>3000 E. Baltimore St/Balto. MD 21224   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <i>Mucus plugging</i><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  | Approximate Interval Between Onset and Death<br>2 weeks                              |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  | b. <i>Cerebrovascular ischemia</i><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  | 2 weeks  |  |
|  |  | c. <i>Asystolic Episode</i><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  | 2 weeks  |  |
|  |  | d.   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Medical resident</i>   |  |  |  | 29c. LICENSE NUMBER<br>9312   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3/29/90                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Irving Weinberg MD PhD, Dept of Medicine, Sinai Hosp at Balto, Balto MD   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 2 - 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rendell</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

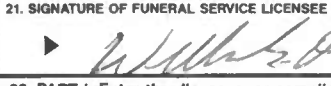

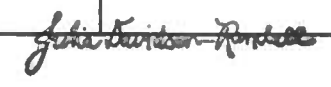
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>George E. Hennessey  |  |  |  | 2. DATE OF DEATH<br>MONTH 4-1-90 DAY YEAR   |  | 3. TIME OF DEATH<br>3:59AM M   |  |
| 4. SOCIAL SECURITY NUMBER<br>214-18-5430   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>68 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>10/13/21                                  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>204 N. Kenwood Avenue   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City                            |  |
| 9c. COUNTY OF DEATH  |  |  |  | 10a. STATE<br>MD  |  |  |  |
| 10b. COUNTY  |  |  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  |  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br>204 North Kenwood Avenue  |  |  |  |
| 10f. ZIP CODE<br>21224   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>white              |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>unknown  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>asbestos worker  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Local # 11  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Andrew John Hennessey   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Anna H. Ritterpusch  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>June G. Hennessey  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>204 North Kenwood Ave/Balto. MD 21224  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Woodlawn Cemetery  |  | 20c. LOCATION — City or Town, State<br>Baltimore, MD  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  | 22. NAME AND ADDRESS OF FACILITY<br>Moran-Ashton Funeral Home, Inc.<br>3000 E. Baltimore St/Balto. MD 21224  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arteriosclerotic cardiovascular disease and Chronic obstructive<br>PULMONARY DISEASE<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Carcinoma of lung  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>4-1-90                                    |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARGARITA A. KORELL, MD 111 Penn Street, Baltimore, MD 21201  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 2 - 1990  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.






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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Ruth I. Hallihan</u>  |  |   |  | 2. DATE OF DEATH<br>MONTH <u>3</u> DAY <u>29</u> YEAR <u>90</u>   |  | 3. TIME OF DEATH<br><u>11:50 p.</u> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><u>132-14-6630</u>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><u>88</u> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><u>8 30 01</u>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><u>New York</u>  |  |   |  | 9. FACILITY NAME (If not institution, give street and number)<br><u>St. Martin's Home for the Aged</u>  |  |  |  |
| 10. CITY, TOWN OR LOCATION OF DEATH<br><u>Catonsville</u>  |  |   |  | 11. COUNTY OF DEATH<br><u>Baltimore</u>   |  |  |  |
| 12a. STATE<br><u>Pa.</u>   |  | 12b. COUNTY<br><u>York</u>  |  | 12c. CITY, TOWN OR LOCATION<br><u>York</u>  |  | 12d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 13a. STREET AND NUMBER<br><u>131 Lehman Dr.</u>  |  |   |  | 13b. ZIP CODE<br><u>17403</u>   |  | 13c. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 14. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 15. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 16. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 17. RACE — American Indian, Black, White, etc.<br>Specify:<br><u>white</u>   |  |
| 18. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u><br>College (1-4 or 5+) <u>College</u>  |  | 19. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>Mental Health Aide</u>           |  | 20. KIND OF BUSINESS/INDUSTRY<br><u>State of New York</u>   |  |  |  |
| 21. FATHER'S NAME (First, Middle, Last)<br><u>William Waugh</u>  |  |   |  | 22. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Nora Holbrook</u>   |  |  |  |
| 23a. INFORMANT'S NAME (Type/Print)<br><u>Mary M. Lane</u>  |  |   |  | 23b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>131 Lehman Drive York, Pa 17403</u>   |  |  |  |
| 24a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 24b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>St. Agnes Cemetery</u>   |  | 24c. LOCATION — City or Town, State<br><u>Syracuse, New York</u>  |  |  |  |
| 25. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 26. NAME AND ADDRESS OF FACILITY<br><u>Hubbard Funeral Home, Inc.</u><br><u>4107 Wilkens Ave. Baltimore, Md. 21229</u>  |  |  |  |
| 27. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Left lower lobe pneumonia.</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <u>Left lower lobe pneumonia.</u><br>b. <u>Left lower lobe pneumonia.</u><br>c. <u>Left lower lobe pneumonia.</u><br>d. <u>Left lower lobe pneumonia.</u><br>Approximate Interval Between Onset and Death<br><u>1 day</u> |  |   |  |   |  | 28. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><u>Severe coronary artery disease, essential hypertension, hypothyroidism, SPM MI in 1983.</u> |  |
| 29. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Severe coronary artery disease, essential hypertension, hypothyroidism, SPM MI in 1983.</u>   |  |   |  |   |  | 30. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 31. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  | 32. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 33. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |   |  | 34. DATE OF INJURY (Month, Day, Year)<br><u>3/29/90</u>   |  | 35. TIME OF INJURY<br><u>M</u>   |  |
| 36. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><u>At home</u>  |  |   |  | 37. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 38. DESCRIBE NOW INJURY OCCURRED<br><u>At home</u>   |  |
| 39. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><u>At home</u>  |  |   |  | 40. DATE SIGNED (Month, Day, Year)<br><u>4/2/90</u>   |  |  |  |
| 41. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  | 42. SIGNATURE AND TITLE OF CERTIFIER<br><u>Komal Dang MD</u>  |  |  |  |
| 43. LICENSE NUMBER<br><u>D18362</u>  |  |   |  | 44. DATE SIGNED (Month, Day, Year)<br><u>4/2/90</u>   |  |  |  |
| 45. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>Dr. Komal Dang 3455 Wilkens Ave. Balto., Md. 21229</u>   |  |   |  |   |  |  |  |
| 46. DATE FILED (Month, Day, Year)<br><u>APR 2 1990</u>   |  |   |  | 47. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be furnished for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |  |   |  |
|---|--|--|--|---|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Stella V. Holmes  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March, 28, 1990   |  |  |  | 3. TIME OF DEATH<br>M  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>218-28-1280  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>78 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>April 14, 1911                             |  | 8. BIRTHPLACE (State or Foreign Country)<br>Virginia   |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Forest Haven Nurs, Home   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Catonsville, Md.   |  |  |  | 9c. COUNTY OF DEATH<br>Balto. Co.  |   |  |
| 10a. STATE<br>Virginia  |  |  | 10b. COUNTY<br>-----   |   |  | 10c. CITY, TOWN OR LOCATION<br>Godvein   |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER  |  |  |  | 10f. ZIP CODE   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                  |  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>None -----   |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home   |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Silas Mercer Holmes, Sr.   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mattie --- Richie  |  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Margaret Claxton  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1606 Jackson St. Balto. Md. 21230  |  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. Holly Baptist Church   |  | 20c. LOCATION — City or Town, State<br>Remington, Va.   |  |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Shaw Savage  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Balto. Md. 21230<br>McCully Funeral Home, 130 E. Fort Ave.  |  |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebral Thrombosis<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death   |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>MULTI INFARCT DEMENTIA  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |   |  |
|   |  |  |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA                        |  | 26. PLACE OF DEATH (Check only one)<br>OTHER:<br>4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                 |  |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE NOW INJURY OCCURRED  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Jasneem Lalena   |  |  |  | 29c. LICENSE NUMBER<br>D28595   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br>3/29/90   |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>TASNEEM CAKIANI, MD 7220 PARK HEIGHTS AVE, BALTO MD 21208  |  |  |  |   |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 2, 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randell  |  |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 must be retained by the hospital or attending physician. Page 5 must be retained by the funeral director. Page 4 must be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Amelia L. HUTTON</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 26 1990</b>  |  | 3. TIME OF DEATH<br><b>9:55 pm. M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-24-7052</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 8. AGE (in yrs. last birthday)<br><b>73</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 2, 1916</b>                            |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Franklin Square Hospital</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rosedale</b>  |  | 9c. COUNTY OF DEATH<br><b>Baltimore Co.</b>  |  |
| 10a. STATE<br><b>Maryland</b>   |  |   |  | 10b. COUNTY<br><b>Balto. City, Md.</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Balto. City, Md.</b>                                 |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br><b>645 E. Clement St.</b>   |  |  |  |
| 10f. ZIP CODE<br><b>21230</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>7th. Grade</b>  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>                                      |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles E. Strecker</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Amelia L. Kohlhoff</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Florence Kramer</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>645 E. Clement St. Balto. Md. 21230</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Glen Haven Memorial Park</b>   |  | 20c. LOCATION — City or Town, State<br><b>Glen Burnie, Md.</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Daniel A. Taylor</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Balto. Md. 21230<br/>McCully Funeral Home, 130 E. Fort Ave.</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrhythmia Secondary to Hypo Kalemia</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive Heart Failure</b><br><b>Chronic Obstructive Pulmonary Disease</b><br><b>Pancreatitis</b>  |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>M</b>                                     |  |
| 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Jeffrey M. Roesch</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>N/A</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-26-91</b>                                  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Jeffrey Roesch, M.D. 9000 Franklin Square Drive, Baltimore, Maryland 21237</b>  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 2 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3 should be retained by the hospital or attending physician. Pages 4 and 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Early Harper</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>03</b> DAY <b>28</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>2:06 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>239-05-9216</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9/24/1911</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>S. CAROLINA</b>  |  |  |  | 9. FACILITY NAME (If not institution, give street and number)<br><b>SINAI HOSPITAL</b>  |  |   |  |
| 10. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  |  |  | 11. COUNTY OF DEATH<br><b>MARYLAND</b>  |  |   |  |
| 12a. STATE<br><b>MARYLAND</b>   |  | 12b. COUNTY  |  | 12c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>  |  | 12d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 13. STREET AND NUMBER<br><b>907 MCKEAN AVENUE</b>   |  |  |  | 14. ZIP CODE  |  | 15. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 16. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 17. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 19. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  |
| 20. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  | 21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |  | 22. KIND OF BUSINESS/INDUSTRY   |  |   |  |
| 23. FATHER'S NAME (First, Middle, Last)<br><b>JIM HARPER</b>  |  |  |  | 24. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CORRIE SIMMONS</b>  |  |   |  |
| 25. INFORMANT'S NAME (Type/Print)<br><b>YVONNE MONTGOMERY</b>   |  |  |  | 26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7655 PINE ST. RURAL HALL, N. CAROLINA 27045</b>  |  |   |  |
| 27. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 28. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>WESTERN STAR CEMETERY</b>  |  | 29. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>  |  |   |  |
| 30. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Leroy O. Dyett</b>  |  |  |  | 31. NAME AND ADDRESS OF FACILITY<br><b>LEROY O. DYETT &amp; SON FUNERAL HOME<br/>4600 LIBERTY HEIGHTS AVENUE</b>  |  |   |  |
| 32. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Bronchogenic Carcinoma</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. Approximate Interval Between Onset and Death: <b>6 months</b> |  |  |  |   |  | 33. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                        |  |
| 34. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  | 35. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 36. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 37. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 38. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 39. DATE OF INJURY (Month, Day, Year)  |  | 40. TIME OF INJURY<br><b>M</b>  |  | 41. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 42. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 43. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 44. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 45. DATE OF INJURY  |  |   |  |
| 46. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 47. SIGNATURE AND TITLE OF CERTIFIER<br><b>Robert B. Snodgrass M.D.</b>   |  |  |  | 48. LICENSE NUMBER<br><b>D36356</b>   |  | 49. DATE SIGNED (Month, Day, Year)<br><b>3/28/90</b>  |  |
| 50. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Robert B Snodgrass M.D. 6804 Park Heights Ave. Balto. MD</b>  |  |  |  |   |  |   |  |
| 51. DATE FILED (Month, Day, Year)<br><b>APR 2 1990</b>  |  |  |  | 52. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be submitted for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br>Gaylord W. Howard  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3-29-90   |  | 3. TIME OF DEATH<br>1:48PM M  |  |
| 4. SOCIAL SECURITY NUMBER<br>214-50-1810   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>42 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>12-28-42  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>MD.  |  | 9a. FACILITY NAME (If not Institution, give street and number)<br>Liberty Medical Center   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |  | 9c. COUNTY OF DEATH   |  |
| RESIDENCE OF DECEASED  |  |  |  |   |  |   |  |
| 10a. STATE<br>MD.  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>406 E. North Ave Apt. A  |  |  |  | 10f. ZIP CODE   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEASED EVER IN U.S. ARMY FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: B  |  |
| 15. DECEASED'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEASED'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Maintenance   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Milton W. Howard  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Estelle Briscoe  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Andrea Harper  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2502 Eutaw Pl Balto, MD. 21217   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Western Star Cemetery  |  | 20c. LOCATION — City or Town, State<br>Catonsville, MD.   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Wm C Brown  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Wm. C. Brown Community F.H.<br>1206 W. North Ave  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arteriosclerotic cardiovascular disease<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>INSPECTION                                |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>XXX YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>XXX Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO               |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>[Signature]   |  |  |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-30-90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>FRANK PERETTI, MD 111 Penn Street, Baltimore, MD 21201 VC   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 2 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>[Signature]  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>VIOLET R. HAHN  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March 28, 1990   |  | 3. TIME OF DEATH<br>M  |  |
| 4. SOCIAL SECURITY NUMBER<br>212-32-9702  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>85 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Dec. 29, 1904   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>1306 Glenmont Road   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Glenmont  |  |
| 9c. COUNTY OF DEATH<br>Baltimore  |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Baltimore   |  |
| 10c. CITY, TOWN OR LOCATION<br>Parkville  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>2414 Woodcroft Road  |  |
| 10f. ZIP CODE<br>21234  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Clerk  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Market   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Harry Welzel   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Margaret Brown  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Lorriane Williams  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1306 Glenmont Road  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Holy Redeemer Cem. 3/31/90   |  | 20c. LOCATION — City or Town, State<br>Baltimore, Md.  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Ronald C. Schaffer Jr.</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>1050 York Road<br>Ruck Towson Funeral Home, Inc. Towson, Md. 21204   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Unstable Coronary Arteries</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <i>Severe Atherosclerotic Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>She was completely bedridden</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  | Approximate interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>B. K. Yorkoff, M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br>D20807  |  | 29d. DATE SIGNED (Month, Day, Year)<br>3/30/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Benjamin K. Yorkoff, M.D. 120 Sister Pierre Drive Towson, Md. 21204  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 2 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within \_\_\_\_\_ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>STEPHEN J. IGNATOWSKI</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 28, 1990</b>   |  | 3. TIME OF DEATH<br><b>3:34 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-09-2512</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>AUG. 3, 1904</b>  |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><b>St. Joseph Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>  |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>BALTIMORE</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>6915 DONACHIE RD.</b>   |  |  |  | 10f. ZIP CODE<br><b>21239</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>4</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>SCHOOL TEACHER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>BALTIMORE CITY</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>STANISLAUS IGNATOWSKI</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>STEPHANIE (UNKNOWN)</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>IRIS M. CRAWFORD</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>837 EWING DR. WESTMINISTER MARYLAND 21157</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>ENTOMBMENT</b>  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>TIMONIUM MARYLAND</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Dennis Capitano</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Leonard J. Ruck, Inc. 5305 Harford Road Balto. Md.</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardio-pulmonary arrest</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Acute Myocardial infarction</b><br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>A-S-C-V-D.</b> |  |  |  |   |  |   | Approximate Interval Between Onset and Death |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D-17992</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-29-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Khin M. Tun, M.D. 1006 Taylor Avenue Towson Md 21204</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 2, 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be released to the funeral director or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>ROSE JORGENSEN   |  |  |  | 2. DATE OF DEATH<br>MONTH 3 DAY 29 YEAR 90  |  | 3. TIME OF DEATH<br>9:50 P. M   |   |
| 4. SOCIAL SECURITY NUMBER<br>214-74-7366   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>85 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>8/17/04  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Frederick Villa Nursing Center   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Catonsville  |  | 9c. COUNTY OF DEATH<br>Baltimore  |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |   |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Howard  |  | 10c. CITY, TOWN OR LOCATION<br>Elkridge   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>5953 Elk Forest Court  |  |  |  | 10f. ZIP CODE<br>21227  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker                       |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Prokopf Pernica   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Annastasia Unknown   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Elsie R. Hartman   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5953 Elk Forest Court Elkridge, MD 21227   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Meadowridge Memorial Park  |  | 20c. LOCATION — City or Town, State<br>Elkridge, Maryland   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Hubbard Funeral Home, Inc.<br>4107 Wilkens Ave. Baltimore, MD 21229   |  |   |   |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) <i>Sepsis</i><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><i>Pneumonia</i><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><i>Infected decubitus ulcer</i><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><i>Days</i><br><i>day</i><br><i>3 months</i>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  |   |  |   |   |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Charles R. Graham</i>  |  |  |  | 29c. LICENSE NUMBER<br>024781   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-30-90  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Charles Graham 299 Frederick Road   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>APR 2 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be supplied by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be attached to the certificate for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20 00217

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1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Norman F. Jubb</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>24</b> YEAR <b>1990</b>   |  | 3. TIME OF DEATH<br><b>5:25 A. M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216 05 7034</b><br><del>XXXXXXXXXX</del>  |  | 5. SEX<br><b>XX</b> M <input type="checkbox"/> F |  | 8. AGE (In yrs. last birthday)<br><b>83</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug. 17, 1906</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Corsica Hill Nursing Home</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Centreville</b>   |  | 9c. COUNTY OF DEATH<br><b>Queen Annes</b>  |  |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>Queen Annes</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Queenstown</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><b>XX</b> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>Rt. 1 Box 138</b>  |  | 10f. ZIP CODE<br><b>21658</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <b>XX</b> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <b>XX</b> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <b>XX</b> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>Supervisor</b>   |  |  |  | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Supervisor</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Andrew Jubb</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Minnie Lewis</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>James P. Griffin</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Rt. 1 Box 82C1, Queen Anne, MD 21657</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <b>XX</b> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holy Cross Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Stacy D. L...</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>McCully Funeral Home of Pasadena<br/>3204 Mountain Rd., Pasadena, MD 21122</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebrovascular Accident</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Atrial Fibrillation</b>  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <b>XX</b> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <b>XX</b> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Stacy D. L...</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D32036</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/24/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Gary D. Sprague, MD PO Box 210 Queenstown, MD 21658</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 2 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

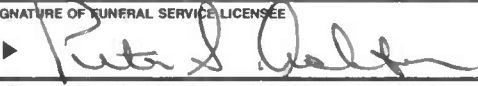




TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Paul Henry Krolus   |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3 / 31 / 1990  |  |   |  | 3. TIME OF DEATH<br>1:00 P <sup>M</sup>  |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>218-10-2674 A  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>75 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>3-18-1915  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>1008 Marlau Drive   |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore   |  |   |  | 9c. COUNTY OF DEATH<br>Baltimore   |  |   |  |  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |
| 10a. STATE<br>Md.   |  | 10b. COUNTY<br>Baltimore   |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore, MD.   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>1008 Marlau Drive   |  |  |  |   |  | 10f. ZIP CODE<br>21212   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                             |  |  |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>High School  |  | College (1-4 or 5 +)<br>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Retail Sales   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Lee Electric  |  |  |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Harry H. Krolus  |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Marie Eisenhohr   |  |   |  |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Ruby Krolus   |  |  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1008 Marlau Drive, Baltimore, Md. 21212 |  |   |  |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Greenmount Crematory   |  |   |  | 20c. LOCATION — City or Town, State<br>Baltimore, Md.  |  |   |  |  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Bradley-Ashton Funeral Home, INC.<br>2134 Willow Spring Rd. Dundalk, MD. 21222                       |  |   |  |  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Metastatic Lung Cancer</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b.<br>c.<br>d.<br>Approximate Interval Between Onset and Death<br>3 MONTHS |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>  |  |  |  |   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                        |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |  |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |   |  |  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br> |  | 29c. LICENSE NUMBER<br>D27730   |  | 29d. DATE SIGNED (Month/Day, Year)<br>4/2/90 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>GARY COHEN, MD. 6165 N. CHAS. ST. BALTO. MD 21204  |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 2 - 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |   |  |  |  |   |  |  |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Ebonie (Eboni Chana Keel) Keel  |  |  |  | 2. DATE OF DEATH<br>MONTH 3 DAY 25 YEAR 90  |  | 3. TIME OF DEATH<br>5:17 M   |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>YRS. 1 MONTHS 7 DAYS  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>2-16-90   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Bon Secours Hospital  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br>Maryland  |  |  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br>2110 W. Saratoga Street   |  | 10f. ZIP CODE<br>21223   |  |
| 10g. CITIZEN OF WHAT COUNTRY?   |  |  |  | 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black  |  | 15. DECEASED'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)                               |  |
| 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  | 17. FATHER'S NAME (First, Middle, Last)<br>Kenneth Keel  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Charlotte R. Williams  |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br>Kenneth Keel  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2110 W. Saratoga Street Baltimore, Md 21223     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. Auburn Cemetery   |  | 20c. LOCATION — City or Town, State<br>Baltimore Maryland  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>▶  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Chatman-Harris F/H Baltimore, Md 21217  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sudden Infant Death Syndrome<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.  |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Frank J. Peretti, M.D.—Assistant   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br>▶   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Frank J. Peretti, M.D.—Assistant 111 Penn St., Baltimore, MD 21201   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 2 - 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rendell   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


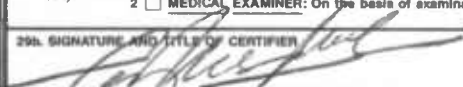

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. XC 046 58 998

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOSEPH CHARLES KRISS</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 29, 1990</b>  |  | 3. TIME OF DEATH<br><b>2:12A</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>216 05 0308</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9-29-18</b>  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>VA MEDICAL CENTER</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>FORT HOWARD, MARYLAND</b>  |   |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>---</b>  |   |
| 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE City, Md.</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>325 S. MACON STREET</b>   |   |
| 10f. ZIP CODE<br><b>21224</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII</b>  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th, Grade</b><br>College (1-4 or 5+) <b>---</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Tailor</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Tailor Shop</b>   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ANDREW KRISS</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>EDNA BEIGEL</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CLINICAL RECORDS, VAMC</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>VA MEDICAL CENTER FORT HOWARD, MARYLAND</b>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Md. Vet. Cemt. Crownsville, Md.</b>   |  | 20c. LOCATION — City or Town, State<br><b>A.A.Co.</b>  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>130 E. Fort Ave. Balto. Md. 21230</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>a. CARDIAC ARRHYTHMIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. ARTERIOSCLEROTIC HEART DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. ---</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d. ---</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>END STAGE RENAL DISEASE</b>   |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |   |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-29-90</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>C.V.L. VERGHESE, M.D. VA MEDICAL CENTER FORT HOWARD, MARYLAND 21052</b>  |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 2 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |   |
|---|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>THELMA T. KAHL  |  |   |  | 2. DATE OF DEATH<br>MONTH 3 DAY 31 YEAR 1990  |  | 3. TIME OF DEATH<br>9:15 A. M  |   |
| 4. SOCIAL SECURITY NUMBER<br>216-05-6753  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>79 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>5-22-10                                    |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>401 N. BEECHWOOD RD.  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>CATONSVILLE  |  | 9c. COUNTY OF DEATH<br>BALTIMORE   |   |
| 10a. STATE<br>MARYLAND  |  |   |  | 10b. COUNTY<br>BALTIMORE  |  | 10c. CITY, TOWN OR LOCATION<br>CATONSVILLE   |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |   |  |  |   |
| 10e. STREET AND NUMBER<br>401 N. BEECHWOOD RD.  |  |   |  | 10f. ZIP CODE<br>21228  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                     |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>SECRETARY  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>INSURANCE COMPANY   |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>JOHN KAHL JR.  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>CATHERINE HETTCH   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>MARGARET THOMPSON   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9408 DAWN DRIVE BALTIMORE, MD 21236  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>WESTERN CEMETERY  |  | 20c. LOCATION — City or Town, State<br>BALTIMORE, MARYLAND  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>L. Witzke</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>1630 EDMONDSON AVE. CATONSVILLE, MD. 21228<br>LEROY M. & RUSSELL C. WITZKE FUNERAL HOME   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <i>Pulmonary edema</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Hypertensive C.V. dis.</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |   |  |   |  |  | Approximate Interval Between Onset and Death<br>10 yr.  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
|   |  |   |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Christina D. Davis M.D.</i>   |  |   |  | 29c. LICENSE NUMBER<br>D10876   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3/31/90                                       |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27), (Type, Print)<br>C. S. MASS 413 Nottingham Rd. Balt. 21229   |  |   |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>APR 2 1990   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 6 and 7 must be completed by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the funeral director's signature should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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90 08523

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MAYNARD JOSEPH KING</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 29 90</b>  |  | 3. TIME OF DEATH<br><b>7:30 P M</b>                                     |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-07-5534</b>   |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>10 9 15</b>                |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>2519 Shurcoller Rd.</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Darlington</b>  |  | 9c. COUNTY OF DEATH<br><b>Harford</b>                                   |  |
| 10a. STATE<br><b>Maryland</b>   |  |   |  | 10b. COUNTY<br><b>Harford</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Abertown</b>                          |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>15 INCA STREET</b>   |  |   |  | 10f. ZIP CODE<br><b>21001</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                           |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b> |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>7th</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Painter</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Contracting</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>M. Rufus King</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ida (unk)</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. Robert King</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1404 Medfield Ave, Baltimore, Maryland 21211</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Green Mount Cem/Crematory</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Md.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>A. Alan Seitz, Jr.</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>A. Alan Seitz, Jr. Funeral Home<br/>3818 Roland Avenue, Balto, Md 21211</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Anteroseptal Myocardial Infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b>   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
|   |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Ear near Marina 2519 Shurcoller Rd</b> |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>3/29/90</b>                |  |
|   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Darlington, MD</b>              |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Richard J. Colfer, M.D.</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>DO 1194</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/30/90</b>                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>RICHARD J. COLFER, M.D.<br/>2013 Temple Church Rd<br/>Darlington, Md 21034</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 2 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Pondell</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3 should be filed within 72 hours after death with the attending physician and completely filled in by the funeral director prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 08524

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |   |
|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BESSIE A. LINDLER</b>   |  | 2. DATE OF DEATH<br>MONTH <b>3</b> - DAY <b>29</b> - YEAR <b>90</b>  |  | 3. TIME OF DEATH<br>M   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>212188707</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (in yrs. last birthday)<br><b>75</b> YRS.  |   |
| 7. DATE OF BIRTH (Month, Day, Year)<br><b>08-25-14</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Md.</b>   |  |   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>BON SECOURS HOSPITAL</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE, MD.</b>   |  | 9c. COUNTY OF DEATH<br><b>N/A</b>   |   |
| 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY<br><b>N/A</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>4514 Manorview Rd. - Baltimore, Md.</b>   |  | 10f. ZIP CODE<br><b>21229</b>   |   |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>N/A</b> |   |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: <b>N/A</b>  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Retired</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Baltimore Business Forms</b>   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Ferdinand M. Walsh</b>   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lydia Brubaker</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. Louis M. Walsh</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4729 Belwood Green-Baltimore, Md. 21227</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>New Cathedral Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Md.</b>  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>G. Truman Schwab</b>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>3512 Frederick Avenue<br/>Baltimore, Md. 21229</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Failure</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>Recurrent Pulmonary Embolism</b><br>c. <b>Coronary Artery Disease</b><br>d. <b>Myocardial Infarction</b> |  |  |  |   | Approximate interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Hypertension</b><br><b>Pneumonia</b><br><b>Anemia</b>   |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John F. ...</b>  |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/29/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ROLAND M. SABUNDAYO, MD.</b>   |  |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 2 - 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>John F. ...</b>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 08525

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Eugene W. Lindemulder  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March 29 1990  |  | 3. TIME OF DEATH<br>9:15A.M.  |  |
| 4. SOCIAL SECURITY NUMBER<br>001-12-5279   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>69 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>5-11-1920   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>7202 York Dr. Dundalk  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Dundalk   |  | 9c. COUNTY OF DEATH<br>Baltimore  |  |
| RESIDENCE OF DECEDENT  |  |   |  |  |  |   |  |
| 10a. STATE<br>MD   |  | 10b. COUNTY<br>Baltimore  |  | 10c. CITY, TOWN OR LOCATION<br>Dundalk   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>7202 York Dr.  |  |   |  | 10f. ZIP CODE<br>21222   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: white                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12)<br>high school   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Security guard                     |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Peter Lindemulder   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Healy  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Eleanor Haley  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7202 York Dr. Dundalk, MD 21222   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Greenmount Crematory  |  | 20c. LOCATION — City or Town, State<br>Balto., MD  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Bradley-Ashton F.H. Dundalk, MD  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |   | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic adenocarcinoma<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.  |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Adrian E. Long MD   |  |   |  | 29c. LICENSE NUMBER<br>D22926  |  | 29d. DATE SIGNED (Month, Day, Year)<br>3/30/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETES CAUSE OF DEATH (ITEM 27) (Type, Print)<br>1447 York Rd Lutherville Md 21093   |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 2 - 1990  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
STATE  
REGISTRAR **BENNIE H. LYON** **STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH** REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Bennie Lyon</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>30</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>1:48 P.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>466-42-4524</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10/18/15</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>TEXAS</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>HOWARD COUNTY GENERAL HOSPITAL</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>COLUMBIA</b>   |  |
| 9c. COUNTY OF DEATH<br><b>HOWARD</b>   |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>HOWARD</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>COLUMBIA</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>11093 WINEGLASS CT.</b>   |  |
| 10f. ZIP CODE<br><b>21044</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b></b>   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>PHOTOGRAMMETRY</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>CIVIL ENGINEER</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>THOMAS J. TEMPLE</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>SARAH E. HERDMAN</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MODESTA LYON</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11093 WINEGLASS CT. COLUMBIA, MD, 21044</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MISSION BURIAL PARK NORTH</b>   |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>SAN ANTONIO, TEXAS</b>   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>5555 TWIN KNOLLS RD. COLUMBIA, MD. 21045</b><br><b>LEROY M. &amp; RUSSELL C. WITZKE FUNERAL HOME</b>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Congestive Heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Coronary artery disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Arterio Sclerosis</b>   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |  |  |
| 29c. LICENSE NUMBER<br><b>D15043</b>   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/30/90</b>  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. JEROME HANTMAN 5755 CEDAR LANE COLUMBIA, MD. 21044</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 2 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 must be signed by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>CARRIE LOKSTEIN</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>03 28 90</i>   |  | 3. TIME OF DEATH<br><i>9:55P M</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>212-05-1598</i>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>83</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>11/25/06</i>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Maryland</i>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>St. Joseph Hospital</i>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Towson</i>  |  |
| 9c. COUNTY OF DEATH<br><i>Baltimore</i>   |  |  |  |   |  |   |  |
| 10a. STATE<br><i>Maryland</i>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><i>Dundalk</i>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><i>1207 Delbert Ave.</i>  |  |  |  | 10f. ZIP CODE<br><i>21222</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>11</i><br>College (1-4 or 5+) <i>Telephone Operator</i>  |  | 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Telephone Operator</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>C. &amp; P. Telephone Co.</i>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Walter Hense</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Janine Kreuger</i>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Joanne L. Stockman</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1718 Killington Rd., Towson, Md. 21204</i>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Holy Redeemer Cemetery 3/31/90</i>  |  | 20c. LOCATION — City or Town, State<br><i>Balto., Md.</i>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Ronald C. Schaefer</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Ruck Towson Funeral Home, Inc.<br/>1050 York Rd., Towson, Md. 21204</i>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>SEPSIS</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><i>PYELONEPHRITIS</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  | Approximate interval between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
|   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Shirley Thompson</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>D33215</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>03/28/90</i>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Shirley Thompson, M.D. St. Joseph Hospital Towson, Md. 21204</i>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>APR 2, 1990</i>   |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. ...</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Donald W. Monaghan</i>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>3 31 90</i>  |  | 3. TIME OF DEATH<br><i>0605 A</i>   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>218-12-4068</i>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><i>72</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>Nov. 27, 1917</i>                                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Baltimore County General Hospital</i>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Randallstown</i>  |  | 9c. COUNTY OF DEATH<br><i>Baltimore</i>   |  |
| 10a. STATE<br><i>Maryland</i>  |  |   |  | 10b. COUNTY<br><i>Baltimore</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>Woodlawn</i>  |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><i>7613 Dogwood Road</i>   |  |   |  | 10f. ZIP CODE<br><i>21207</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>                                       |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>Caucasian</i>              |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Restaurant &amp; Tavern</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Owner</i>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Peter Howard Monaghan</i>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Ida Gertrude Mullineaux</i>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Patrick Wesley Monaghan</i>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2009 Hillside Drive Woodlawn, MD 21207</i>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Entombment</i>  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Woodlawn Mausoleum</i>   |  | 20c. LOCATION — City or Town, State<br><i>Woodlawn, Maryland</i>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Joseph D. W. Kellner</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Loring Byers Funeral Directors, INC.<br/>8728 Liberty Rd. Randallstown, MD 21133-4784</i>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Right lower lobe pneumonia</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. <i>Congestive Heart Failure</i><br>c. <i>Cardiopulmonary Arrest</i> |  |   |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
|  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURED   |  |   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Gregory S. Gordon, MD</i>  |  |   |  | 29c. LICENSE NUMBER<br><i>D39269</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>3-31-90</i>                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Baltimore County General Hospital</i>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>APR 2 - 1990</i>   |  | 32. REGISTRAR'S SIGNATURE<br><i>Judith Davidson-Randell</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be filled in by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


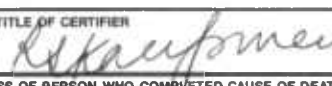
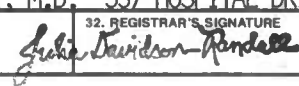
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JAMES L. MCKENNEY</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>27</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>8:00 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216 42 1347</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>45</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Oct. 3, 1944</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>North Arundel Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Glen Burnie</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Anne Arundel</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Pasadena</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>1089 Wood Lawn Ave.</b>   |  |
| 10f. ZIP CODE<br><b>21122</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>Vietnam Conflict</b>   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>Long Shoreman</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>ITO Corp.</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William T. McKenney</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Edna H. Johnson</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Martha McKenney</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1089 Wood Lawn Ave., Pasadena, MD 21122</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>McCully Funeral Home of Pasadena<br/>3204 Mountain Rd., Pasadena, MD 21122</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Intra cerebral hemorrhage</b>   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF): <b>Coma</b>   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF): <b>respiratory failure</b>  |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> NO   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURED   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br><b>D26307</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/27/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>RANI S. KARPINEN, M.D. 337 HOSPITAL DRIVE, BLDG. B, GLEN BURNIE, MARYLAND 21061</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 2 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |   |   |   |  |   |  |
|--|--|--|--|--|--|---|--|---|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Revvia Moore</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>03</b> DAY <b>31</b> YEAR <b>90</b>   |  |   |  | 3. TIME OF DEATH<br><b>1 7 PM</b>   |   |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-01-1113D</b>   |  |  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>(83) 83 YRS.</b>   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>4/28/06</b>  |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>North Carolina</b> |  |   |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><b>Keswick Nursing Home</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>700 W. 40th St. Balto Md 21211</b>   |  |   |  | 9c. COUNTY OF DEATH<br><b>none</b>  |   |   |  |   |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |  |   |  |   |   |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY<br><b>none</b>   |  |   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore City</b>  |   |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>2120 E. Biddle Street</b>   |  |  |  |  |  | 10f. ZIP CODE<br><b>21213</b>   |  |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>     |   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |   |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Negroid Black</b>                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th grade</b><br>College (1-4 or 5+) <b>none</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Canner</b>   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Packing Company</b>  |   |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Ceasar Green</b>   |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Alberta Lee</b>   |  |   |   |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Eddie Moore</b>   |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>#5 Paula Place, Baltimore Co, Md. 21237</b> |  |   |   |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Baltimore Cemetery</b>  |  |   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>   |   |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Calvin B. Scruggs Jr.</b>  |  |  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Calvin B. Scruggs Funeral Home<br/>1412 E. Preston St. Balto, Md 21213</b>                               |  |   |   |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |   |  |   |   |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |  |  |   |  |   |   | Approximate Interval Between Onset and Death                      |  |   |  |
| a. <b>Cardiac Arrest (CARDIAC ARREST)</b> 3 min.   |  |  |  |  |  |   |  |   |   | 3 min   |  |   |  |
| b. <b>Alzheimer's Disease (Alzheimer's)</b>  |  |  |  |  |  |   |  |   |   | years   |  |   |  |
| c. <b>Hypertensive Cardiac Vascular Disease</b>  |  |  |  |  |  |   |  |   |   | years   |  |   |  |
| d.   |  |  |  |  |  |   |  |   |   |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |   |  |   |   |   |  |   |  |
| - <b>Decubitus ulcer on hip</b>  |  |  |  |  |  |   |  |   |   |   |  |   |  |
| - <b>Hypertension</b>  |  |  |  |  |  |   |  |   |   |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |   | 28d. DESCRIBE HOW INJURY OCCURRED                                 |  |   |  |
|  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |   |  |   |   |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Joseph W. Zabolyn</b>  |  |  |  |  |  | 29c. LICENSE NUMBER<br><b>022334</b>  |  |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>31 March 90</b> |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Keswick Nursing Home</b>   |  |  |  |  |  |   |  |   |   |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 2 1990</b>   |  |  |  |  |  |   |  |   |   |   |  |   |  |
| 32. REGISTRAR'S SIGNATURE<br><b>Jake Davidson-Randall</b>  |  |  |  |  |  |   |  |   |   |   |  |   |  |

BALTIMORE MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 must be attached to the hospital or attending physician. Page 6 must be attached to the funeral director, or detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>ELIZABETH B. MacLEOD   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 31, 1990  |  | 3. TIME OF DEATH<br>6:20 PM   |  |
| 4. SOCIAL SECURITY NUMBER<br>219-40-7638   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>90 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>August 25, 1899   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Lorien Nursing Center   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Columbia   |  |
| 9c. COUNTY OF DEATH<br>Howard  |  |  |  | 10a. STATE<br>MD  |  | 10b. COUNTY<br>HOWARD   |  |
| 10c. CITY, TOWN OR LOCATION<br>ELLCOTT CITY  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>9448 TILLER DRIVE   |  |
| 10f. ZIP CODE<br>21043   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) College (1-4 or 5+) 2 yrs  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Housewife  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>William Beard   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Elisa Motter   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Helen M. White   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9448 TILLER DRIVE ELLCOTT CITY MD. 21043   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Metro Crematory   |  | 20c. LOCATION — City or Town, State<br>Catonsville  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>R. Craig Witzke Jr.   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Leroy M. & Russell C. Witzke Funeral Home<br>1630 Edmondson Ave. Catonsville MD 21228   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <u>respiratory arrest</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>organic brain syndrome</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <u>breast cancer</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br>2 1/2 years |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Carol G. Shapiro, M.D.  |  |  |  | 29c. LICENSE NUMBER<br>D28628   |  | 29d. DATE SIGNED (Month, Day, Year)<br>4-1-90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>4501 Old Annapolis Rd. Ellicott City, MD 21043  |  |  |  |   |  |   |  |
| 31. DATE<br>APR 2 1990   |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be completed by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>James M. O'Donnell   |  |  |  | 2. DATE OF DEATH<br>MONTH 3 DAY 31 YEAR 90  |  | 3. TIME OF DEATH<br>2:25AM M  |   |
| 4. SOCIAL SECURITY NUMBER<br>216-94-4457   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>25 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>5-26-64   |   |
| 8. FACILITY NAME (If not institution, give street and number)<br>Junction MD Rt 108 & Old Waterloo Rd.   |  |  |  | 9. CITY, TOWN OR LOCATION OF DEATH<br>Howard County   |  | 10. COUNTY OF DEATH<br>Howard County  |   |
| 11. STATE<br>MARYLAND  |  | 12. COUNTY<br>HOWARD   |  | 13. CITY, TOWN OR LOCATION<br>COLUMBIA  |  | 14. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |   |
| 15. STREET AND NUMBER<br>9261 GRAPEWINE COURT  |  |  |  | 16. ZIP CODE<br>21045   |  | 17. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |
| 18. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 19. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 21. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                                 |   |
| 22. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 2 College (14 or 5+)   |  | 23. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>POLICEMAN  |  | 24. KIND OF BUSINESS/INDUSTRY<br>BALTIMORE CITY POLICE DEPT.  |  |   |   |
| 25. FATHER'S NAME (First, Middle, Last)<br>CHARLES J. O'DONNELL  |  |  |  | 26. MOTHER'S NAME (First, Middle, Maiden Surname)<br>MARION HOGAN   |  |   |   |
| 27. INFORMANT'S NAME (Type/Print)<br>CHARLES J. O'DONNELL  |  |  |  | 28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9261 GRAPEWINE COURT. COLUMBIA, MD 21045  |  |   |   |
| 29. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 30. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>ST. JOHN CEMETERY   |  | 31. LOCATION — City or Town, State<br>ELLCOTT CITY, MD  |  |   |   |
| 32. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 33. NAME AND ADDRESS OF FACILITY<br>LEROY M & RUSSELL C WITZKE FUNERAL HOME<br>5555 TWIN KNOLLS ROAD COLUMBIA, MD 21045   |  |   |   |
| 34. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple injuries<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | 35. Approximate interval between Onset and Death  |
| 36. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 37. 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 38. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |   |   |
| 39. 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 40. 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) Scene |  |   |  |   |   |
| 41. 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Could not be determined   |  | 42. 28a. DATE OF INJURY<br>(Month, Day, Year)<br>3-31-90   |  | 43. 28b. TIME OF INJURY<br>1:40AM   |  | 44. 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 45. 28d. DESCRIBE HOW INJURY OCCURRED<br>Driver in auto/fixed object   |  | 46. 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>Junction MD RT 108/Old Waterloo Rd., Howard County, Maryland   |  |   |  |   |   |
| 47. 29. CERTIFIER<br>(Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   | 48. 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |
| 49. 29c. LICENSE NUMBER<br>OCME  |  |  |  |   |  |   | 50. 29d. DATE SIGNED (Month, Day, Year)<br>3-31-90  |
| 51. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Ann M. Dixon, MD 111 Penn Street, Baltimore, MD 21201   |  |  |  |   |  |   |   |
| 52. 31. DATE FILED (Month, Day, Year)<br>APR 2 1990  |  | 53. 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SC-100

90 08533

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>STELLA PANOS   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>03 26 90   |  | 3. TIME OF DEATH<br>11:59 P M  |  |
| 4. SOCIAL SECURITY NUMBER<br>215 48 0448   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>84 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>12/06/05  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Sparta Greece  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>GREATER BALTIMORE MEDICAL CENTER   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>TOWSON  |  |
| 9c. COUNTY OF DEATH<br>BALTIMORE   |  |   |  | 10a. STATE<br>MD   |  | 10b. COUNTY<br>BALTIMORE   |  |
| 10c. CITY, TOWN OR LOCATION<br>Baltimore   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>6607 OLD HARFORD ROAD  |  |
| 10f. ZIP CODE<br>21214   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8                           |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Restaurant Owner   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  | 17. FATHER'S NAME (First, Middle, Last)<br>Anastasios Kourniotis   |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Demetra Pavleros  |  |   |  | 19a. INFORMANT'S NAME (Type/Print)<br>Mr. Louis G. Panos   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1914 Lyden Road Lutherville, Maryland 21093     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Greek Orthodox Cemetery 3/30/90  |  | 20c. LOCATION — City or Town, State<br>Baltimore Maryland  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael Duck</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Ruck Towson Funeral Home, Inc. 1050 York Road  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>INCESSANT</u>   |  |   |  |  |  |  |  |
| a. <u>INCURRENT VENTRICULAR TACHYCARDIA</u><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |  |  |
| b. <u>CONGESTIVE HEART FAILURE</u><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |  |  |
| c. <u>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</u><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |  |  |
| d.   |  |   |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>RECENT AORTIC VALVE REPLACEMENT SURGERY AND</u><br><u>CORONARY ARTERY BYPASS</u>  |  |   |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Donald W. Schechter, MD</i>  |  |   |  | 29c. LICENSE NUMBER<br>D32338  |  | 29d. DATE SIGNED (Month, Day, Year)<br>3/27/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DR RONALD SCHECHTER 6701 N CHARLES STREET TOWSON MD 21204   |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 2 1990  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

501-1-12

90 08534

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Eusebio M. Rivera</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>25</b> YEAR <b>1990</b>   |  | 3. TIME OF DEATH<br><b>5:21 A M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>11-05-0129</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>91</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>12-12-98</b>  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>PUEBLO Rico</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Ben Secours Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |   |
| 9c. COUNTY OF DEATH  |  |  |  | 10. RESIDENCE OF DECEDENT   |  |   |   |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>1004 Popular Grove Street</b>   |  |  |  | 10f. ZIP CODE   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>HISPANIC</b>                   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>TRUCK DRIVER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>JULIA RIVERA</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>LYDIA L. RIVERA</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1004 Popular Grove St. Baltimore, MD</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ARBUTH NOTEMENTAL Park</b>  |  | 20c. LOCATION — City or Town, State<br><b>ARBUTHS MARYLAND</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Berry Davis</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>CHATHAM-HALLS FH 1701 McCullough St Baltimore, MD 21217</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <b>acute myocardial infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>James Evans MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>MD0040</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/5/90</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br><b>200 Washington Blvd Baltimore, Md 21230</b>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 2 - 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

PAGES 1, 2, 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE PRIOR TO BURIAL, CREMATION, OR REMOVAL.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 03234

90 08535

1 - FOR STATE REGISTRAR JOHN V. RIZZOTTI **STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH** REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>John V. Rizzotti</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 30 90</b>   |  | 3. TIME OF DEATH<br><b>9:23 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>103-20-9130</b>  |  | 5. SEX<br><b>XX M 2 F</b>   |  | 6. AGE (In yrs. last birthday)<br><b>61</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>04-20-28</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>223 MALLOW HILL ROAD</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  | 9c. COUNTY OF DEATH<br>-----   |  |
| RESIDENCE OF DECEASED  |  |   |  |   |  |  |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br>-----  |  | 10c. CITY, TOWN OR LOCATION<br><b>223 MALLOW HILL ROAD</b>  |  | 10d. INSIDE CITY LIMITS?<br><b>XX</b> YES 2 NO   |  |
| 10e. STREET AND NUMBER<br><b>223 MALLOW HILL ROAD</b>  |  |   |  | 10f. ZIP CODE<br><b>21229</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>2-1-46--2-2-48</b>  |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |
| 15. DECEASED'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) -----   |  | 16a. DECEASED'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>COURIER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>CONTINENTAL COURIER</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHN F. RIZZOTTI</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>JULIA PERETTI</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>DOROTHY RIZZOTTI</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>223 MALLOW HILL ROAD BALTIMORE, MD 21229</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) -----  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>METRO CREMATORY</b>  |  | 20c. LOCATION — City or Town, State<br><b>CATONSVILLE, MD</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Leroy M. Witzke</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROY M &amp; RUSSELL C WITZKE FUNERAL HOME</b><br><b>1630 EDMONDSON AVE., CATONSVILLE, MD 21228</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  | Approximate Interval Between Onset and Death   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>END-Stage Esophageal Cancer</b>   |  |   |  |   |  | <b>Jan '89</b>   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  | <b>to March '90</b>  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |   |  |   |  | <b>(15 months)</b>   |  |
| a. <b>Esophageal Cancer</b>  |  |   |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |  |  |
| b. -----   |  |   |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |  |  |
| c. -----   |  |   |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |  |  |
| d. -----   |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>None</b>  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
|  |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) ----- |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>N/A.</b>  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Arif Hussain MD</i>  |  |   |  | 29c. LICENSE NUMBER<br><b>D33759</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/31/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>22 S. GREENE ST. BALTIMORE, MD. 21201</b>  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 2 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be required by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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235718 111 03/12/90  
REIER, HENRY  
SEBASTIAN M.D., RUBEN S  
H886 PAD CAG

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1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Henry Reier</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-30-90</b>  |  | 3. TIME OF DEATH<br><b>2:30 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-36-4252</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>86</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>AUG. 16, 1903</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>ST. JOSEPH HOSP.</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>TOWSON</b>  |  | 9c. COUNTY OF DEATH<br><b>BALTO. CO.</b>   |  |
| 10a. STATE<br><b>MARYLAND</b>   |  |  |  | 10b. COUNTY<br><b>BALTO. CO.</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>GLEN ARM, MD.</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>11000 FACTORY ROAD</b>   |  |  |  | 10f. ZIP CODE<br><b>21057</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American-Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>-</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>FARMER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ANTON REIER</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>WILHELMIA WEINRICH</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>FAMILY RECORDS</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>SAME AS ABOVE</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>PARKWOOD CEM.</b>   |  | 20c. LOCATION — City or Town, State<br><b>PARKVILLE, MD.</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>J. J. J. J.</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>EVANS FUNERAL CHAPEL<br/>PARKVILLE MD. 21234-4196</b>  |  |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Pulmonary edema</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>b. Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>d.</b> |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
|   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Natividad D. de Leon, M.D.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>819508</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/30/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>NATIVIDAD D. DE LEON, 40 ST. JOSEPH HOSPITAL, TOWSON, MD. 21204</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 2 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Margaret E. Smith</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-30-90</b>   |  | 3. TIME OF DEATH<br><b>1226 P.M.</b>                                       |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-24-9564</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2-3-27</b>                       |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>St Joseph Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>   |  | 9c. COUNTY OF DEATH<br><b>BALTO.</b>                                       |  |
| 10a. STATE<br><b>MD</b>   |  |  |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Randallstown</b>                         |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  |  |
| 10e. STREET AND NUMBER<br><b>4016 Carthage Rd</b>   |  |  |  | 10f. ZIP CODE<br><b>21133</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                             |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b> |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2nd Grade</b><br>College (1-4 or 5+) <b>Housewife</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>                |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Leonard Lambie</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Schwartz</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. William Smith</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4016 Carthage Road Randallstown, Maryland 21133</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Loudon Park Mausoleum</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John E. Evans</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Road Randallstown, MD 21133</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>Probable fresh myocardial infarction<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Arteriosclerotic coronary artery disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>ASCVD<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>Fresh coronary artery bypass<br>Replacement of mitral valve prosthesis |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>Minutes</b><br><b>2 yrs</b><br><b>4 yrs</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>C. Milton Linticum M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D-05971</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Mar 30, 1990</b>                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>C. MILTON LINTICUM, M.D. ST. JOSEPH HOSP. TOWSON, MD</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 2 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

562-72

1944-45

1945-46

1946-47

1947-48

1948-49

1949-50

1950-51

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2002-03

2003-04

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Francis Anthony Sherry</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH <i>3</i> DAY <i>30</i> YEAR <i>90</i>   |  | 3. TIME OF DEATH<br><i>11:05 P M</i>   |   |
| 4. SOCIAL SECURITY NUMBER<br><i>217 07 4294</i>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>73</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>11-9-16</i>  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Good Samaritan Hospital</i>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore</i>   |  | 9c. COUNTY OF DEATH<br><i>City</i>   |   |
| 10a. STATE<br><i>Md.</i>  |  |  |  | 10b. COUNTY<br>-----  |  | 10c. CITY, TOWN OR LOCATION<br><i>Baltimore</i>  |   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |  |   |
| 10e. STREET AND NUMBER<br><i>5106 Frankford Avenue</i>  |  |  |  | 10f. ZIP CODE<br><i>21206</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>                                      |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>2</i> College (1-4 or 5+) <i>2</i>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Sheet Metal Worker</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Bethlehem Shipyard</i>   |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Stanley Sherry</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Anna</i>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Francis R. Sherry</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>300 S. Drew St. Balto., Md. 21224</i>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>St. Stanislaus Cemetery</i>   |  | 20c. LOCATION — City or Town, State<br><i>Balto. City, Md.</i>  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charles S. Zeiler</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Charles S. Zeiler &amp; Son Inc. 6224 Eastern Ave.</i>   |  |  |   |
| 23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardio Respiratory arrest</i><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF): <i>Terminal Cancer Esophagus</i><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Malnutrition</i>   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                 |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>G. Surawany MD Staff Surgeon</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>D17005</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>3/30/90</i>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Good Samaritan Hospital</i>   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><i>APR 2 - 1990</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The death certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR  
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH  
REG. NO.

90 08539

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Alexander B. Smith, SR.</b>   |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>29</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>7:45 PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-01-4247</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>91</b> YRS.  |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>9 12 1898</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>   |  | 9. FACILITY NAME (If not institution, give street and number)<br><b>Veterans Administration Hosp</b>  |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>BALTIMORE</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>526 CHATEAU AVE</b>  |  | 10f. ZIP CODE<br><b>21212</b>   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>   |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>JANITOR</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>JAMES Thomas</b>  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY MUELS</b>   |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>RAYMOND Smith</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1513 PENTRIDGE ROAD BALTIMORE, MD 21239</b>   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Pleasant Rest Cemetery Towson Maryland</b>   |  | 20c. LOCATION — City or Town, State<br><b>Towson Maryland</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Dewey Harris</b>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>CHATMAN-HARRIS FH. 1701 McMillan St BALTIMORE, MD 21202</b>  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cardiopulmonary Arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>N/A</b>  |  |
| 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>E. COHN, MD</b>  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/29/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>E COHN, MD VA Hospital Baltimore, MD</b>   |  | 31. DATE FILED (Month, Day, Year)<br><b>APR 2 - 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Johanna Davidson-Randall</b>  |  |

001-1 00



90 08540

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>CATHERINE ANNA STAHL   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3 31 90   |  | 3. TIME OF DEATH<br>3:55 A M  |   |
| 4. SOCIAL SECURITY NUMBER<br>212-05-0241   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>86 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>8/2/03  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Jenkins Memorial Home  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore  |  | 9c. COUNTY OF DEATH   |   |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>1919 Casadel Avenue  |  |  |  | 10f. ZIP CODE<br>21230  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) 8th grade<br>College (1-4 or 5+)   |  | 18a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Telephone Operator              |  | 18b. KIND OF BUSINESS/INDUSTRY<br>C & P Telephone Co.   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>George Adam Smith   |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Barbara May  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Frances M. Sauble  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1716 De Soto Road Baltimore, Maryland 21230  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Glen Haven Memorial Park   |  | 20c. LOCATION — City or Town, State<br>Glen Burnie, Maryland  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>▶ Jackie D. Shannon   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Hubbard Funeral Home, Inc.<br>4107 Wilkens Ave. Baltimore, Md. 21229  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARDIAC ARRHYTHMIA</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>HASCD</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate interval Between Onset and Death<br>DAYS<br>YRS.  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |   |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>John F. Hartman, M.D.   |  |  |  | 29c. LICENSE NUMBER<br>D0-5403  |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-31-90  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>JOHN F. HARTMAN, M.D. JENKINS MEM. 1000 S. CATON AVE. 21229   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>APR 2 1990  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 08541

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>John Safford Slattery</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 28 1990</b>   |  | 3. TIME OF DEATH<br><b>824 P.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>495 013815</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>July 31 1920</b>   |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>3 TURNER WOOD COURT</b>  |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALOWIN</b>  |  | 8c. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |
| 9a. RESIDENCE OF DECEDENT<br>10a. STATE<br><b>MARYLAND</b>  |  |  |  | 10b. COUNTY<br><b>BALTIMORE</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALOWIN</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>3 TURNER WOOD COURT</b>   |  | 10f. ZIP CODE<br><b>21013</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>W-W-II</b> |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12)<br><b>12 YRS</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>SELF EMP.</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>MAN. REP. HOUSE WARE</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ALLAN WM. SLATTERY</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY SAFFORD</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>FAMILY RECORDS</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>SAME AS ABOVE</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GARRISON FOREST</b>   |  | 20c. LOCATION — City or Town, State<br><b>GARRISON, MO.</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>[Signature]</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>EVANS CHAPEL OF CHIMES<br/>2325 YORK ROAD - Timonium</b>  |  |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Gummed wound of Head</b><br>Approximate Interval Between Onset and Death<br><b>Immediate</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Depression</b>   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature] Deputy Medical Examiner</b>  |  | 29c. LICENSE NUMBER<br><b>001085</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>March 28, 1990</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Stanley Z. Feingersh MD 11 E. Chase St. 2nd fl.</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 2 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. Pages may be retained by the funeral director. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general introduction to the subject of the study.

2. The second part of the report is a detailed description of the methods used in the study.

3. The third part of the report is a discussion of the results of the study.

4. The fourth part of the report is a conclusion and a list of references.

5. The fifth part of the report is a list of appendices.

6. The sixth part of the report is a list of figures and tables.

7. The seventh part of the report is a list of footnotes.

8. The eighth part of the report is a list of symbols and abbreviations.

9. The ninth part of the report is a list of acknowledgments.

10. The tenth part of the report is a list of references.

11. The eleventh part of the report is a list of appendices.

12. The twelfth part of the report is a list of figures and tables.

13. The thirteenth part of the report is a list of footnotes.

14. The fourteenth part of the report is a list of symbols and abbreviations.

15. The fifteenth part of the report is a list of acknowledgments.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |   |
|---|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Charles A. Smith  |  |  |  | 2. DATE OF DEATH<br>MONTH 3 DAY 28 YEAR 90   |  | 3. TIME OF DEATH<br>5:38AM M  |   |
| 4. SOCIAL SECURITY NUMBER<br>215-30-8905  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>57 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>12-14-32   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>4354 Eldone Road   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |   |
| 9c. COUNTY OF DEATH   |  |  |  | 10a. STATE<br>Md.  |  | 10b. COUNTY   |   |
| 10c. CITY, TOWN OR LOCATION<br>Baltimore City   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>4354 Eldone Road  |   |
| 10f. ZIP CODE<br>21229  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |   |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)                                  |   |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Chauffeur   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>George Williams  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Marian Smith  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Marian Smith  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4354 Eldone Rd Balto. City, 21229   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Garrison Forest  |  | 20c. LOCATION — City or Town, State<br>Owings Mills, Md.  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>William C. Brown   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>William C. Brown F.H. 1206 W. North Ave  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACQUIRED IMMUNE DEFICIENCY SYNDROME<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>INSPECTION |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Julia C. Goodin, MD  |  |  |  | 29c. LICENSE NUMBER<br>OCME  |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-28-90  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>JULIA C. GOODIN, MD 111 Penn Street, Baltimore, MD 21201   |  |  |  |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>APR 2 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rendell  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11-11-11



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>HELEN V. SULLIVAN  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3 29 90   |  | 3. TIME OF DEATH<br>8:15 A. M  |  |
| 4. SOCIAL SECURITY NUMBER<br>215-01-3252   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>90 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>12-01-99   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |  |  | 9a. FACILITY NAME (If not Institution, give street and number)<br>Manor Care Rossville  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore, Maryland   |  |
| 9c. COUNTY OF DEATH<br>Baltimore 21237   |  |  |  | 10a. STATE<br>Maryland  |  | 10b. COUNTY  |  |
| 10c. CITY, TOWN OR LOCATION<br>Baltimore City  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>2701 Louise Ave.   |  |
| 10f. ZIP CODE<br>21214   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) Unknown<br>College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Housewife  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Unknown King  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>UNKNOWN  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Elizabeth Kiefner   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5826 Farmview Ave. Baltimore, Md. 21206  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Parkwood 3-31-90  |  | 20c. LOCATION — City or Town, State<br>Parkville, Balto. Md.   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Paul L. Hartsock, Jr.<br><i>Paul L. Hartsock, Jr.</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Leonard J. Ruck, Inc.<br>5305 Harford Rd., Balto. Md. 21214   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardio pulmonary Arrest</i>   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF): <i>G.I. Bleeding</i>  |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF): <i>Coronary artery Dx</i>   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF): <i>Hypertension / HCD</i>   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Osteo-arthritis</i>   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>M. N. Khan M.D.</i>  |  |  |  | 29c. LICENSE NUMBER<br>D 25391  |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-29-90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Mohammed N. Khan, M.D. Good Samaritan Hospital, Baltimore, Maryland   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 2 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Elsie E. SHERMAN</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 / 29 / 90</b>  |  | 3. TIME OF DEATH<br><b>7:35 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>225-03-9937</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan. 4, 1910</b>                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Franklin Square Hospital</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rossville</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore County</b>                               |  |
| 10a. STATE<br><b>Maryland</b>   |  |   |  | 10b. COUNTY<br><b>Baltimore City</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore City</b>                         |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br><b>6013 Winthrop Ave.</b>   |  |  |  |
| 10f. ZIP CODE<br><b>21206</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>8th</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Carl Lee Graham</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Maude Lee Bocock</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. John W. Musgrove</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as Line 10</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Glen Haven 3/31/90</b>   |  | 20c. LOCATION — City or Town, State<br><b>Glen Burnie, Md.</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Paul L. Hartsock, Jr.</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Baltimore, Md. 21214</b><br><b>Leonard J. Ruck, Inc. 5305 Harford Rd.</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Sepsis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>Abdominal Abscess</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____ |  |   |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Aaron Green</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>N/A</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/29/90</b>                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Aaron Green 9000 Franklin Square Drive Baltimore, Maryland 21237</b>  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 2, 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Shelia Davidson-Randall</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1927-28



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BRUCE E. TAYLOR</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 29, 1990</b>   |  | 3. TIME OF DEATH<br><b>8:40 P. M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>030-10-7017</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>NOV. 21, 1912</b>                                  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>BON SECOUR EXTENDED CARE FACILITY</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ELLICOTT CITY</b>   |  | 9c. COUNTY OF DEATH<br><b>HOWARD</b>  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>HOWARD</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>COLUMBIA</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>9774 POLISHED STONE</b>   |  |  |  | 10f. ZIP CODE<br><b>21046</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>MANAGER</b>                                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>HOTEL</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHN S. TAYLOR</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>JENNIE B. FRENCH</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>LEWIS LARSON</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9774 POLISHED STONE, COLUMBIA, MARYLAND 21046</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>METRO CREMATORY</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Russell Craig Witzke</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROY M. &amp; RUSSELL C. WITZKE FUNERAL HOMES</b><br><b>5555 TWIN KNOLLS ROAD, COLUMBIA, MD. 21045</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Respiratory Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Bladder CA metastatic to liver</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic anemia, Protein malnutrition.</b>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |  |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Jon Minford</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>030573</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-30-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JON MINFORD M.D. 2000 CENTURY PLAZA # 424, COLUMBIA, MD.</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 2 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as a transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MARCELLA LOUISE TRACEY  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>April 1, 1990  |  | 3. TIME OF DEATH<br>2:12 A M   |  |
| 4. SOCIAL SECURITY NUMBER<br>212-28-0018  |  | 5. SEX<br>1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>58 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>4-24-1931   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Baltimore County Gen. Hospital   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Randallstown  |  |
| 9c. COUNTY OF DEATH<br>Baltimore Co.  |  |   |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Baltimore Co.   |  |
| 10c. CITY, TOWN OR LOCATION<br>Owings Mills   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>49 Maybin Circle   |  |
| 10f. ZIP CODE<br>21117  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (14 or 5 +)<br>9 Years  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Assembler  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Tool Manufacturing   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Clarence W. Burnham  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Maud E. Morris  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Patricia A. Norris  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10 Rose St. Timonium, Maryland 21093  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mays Chapel Cemetery  |  | 20c. LOCATION — City or Town, State<br>Balto. Co., Maryland  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>William E. Johnson   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>William E. Johnson, P.A. Funeral Home<br>8521 Loch Raven Blvd. Towson, MD 21204  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  | a. Acute Myocardial Infarction<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |
|   |  | b. Severe Coronary artery Disease<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |
|   |  | c. Diabetes<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |
|   |  | d.  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>George Wilson  |  | 29c. LICENSE NUMBER<br>D26475  |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/2/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 2, 1990  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rendall   |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The physician retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>THOMAS ANTHONY TOSCHES  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3-29-1990   |  | 3. TIME OF DEATH<br>2:25 A. M.   |  |
| 4. SOCIAL SECURITY NUMBER<br>215-14-9222  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>67 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>2-18-1923                                  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Good Samaritan Hospital   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore                                     |  |
| 9c. COUNTY OF DEATH   |  |   |  |   |  |  |  |
| 10a. STATE<br>Maryland  |  |   |  | 10b. COUNTY<br>Baltimore  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>2726 Louise Ave.  |  |   |  | 10f. ZIP CODE<br>21214  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WWII  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12 Yrs.  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>College (1-4 or 5+)<br>4 Yrs.<br>Electrical Engineer   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Baltimore City (Civil Service)  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Louis Tosches  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Olivia C. Rosasco  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Grace T. Valle  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8702 Maravoss La., Balto., Md. 21234   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Parkwood Cemetery 3-31-90   |  | 20c. LOCATION — City or Town, State<br>Balto., Md.  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Roy H. Cather<br><i>Roy H. Cather</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Leonard J. Ruck, Inc., 5305 Harford Rd., Balto., Md. 21214  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |   |  |   |  |  |  |
| a. Cerebrovascular Accident   |  |   |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |  |  |
| b. Hypertension   |  |   |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |  |  |
| c. Diabetes Mellitus  |  |   |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |  |  |
| d.  |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
|   |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28e. DESCRIBE HOW INJURY OCCURED  |  |  |  |
|   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Eiad Mirzama</i>  |  |   |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-29-90                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Good Samaritan Hospital, Baltimore, MD   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>3-29-1990  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Rendell</i>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. From the time of death, the body must be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1/27/02

1/27/02



90 08548

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Lena Jean Valerie</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>28</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>12:05 A</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-32-2909</b>  |  | 5. SEX<br><b>1</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Nov. 8, 1912</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Francis Scott Key Med. Center</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore, Maryland</b>   |  | 9c. COUNTY OF DEATH  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |
| 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO    |  |
| 10e. STREET AND NUMBER<br><b>232 S. Clinton Street</b>   |  |  |  | 10f. ZIP CODE<br><b>21224</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br><b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (9-12)</b><br><b>8th</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>home</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Patrick Villano...</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Anna Dattory</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Albert Valerie</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>232 S. Clinton Street, 21224</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gardens of Faith Cemetery Baltimore, Md.</b>  |  | 20c. LOCATION — City or Town, State   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Maria B. Zourenko</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>263 S. Conkling Street, 21224</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrest</b><br>Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {<br><b>End stage Renal Failure</b><br><b>Metastatic Breast CA</b><br><b>Pleural Effusion</b> |  |  |  |   |  |  | Approximate interval Between Onset and Death<br><b>Immed.</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                       |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Gregory Dean Mieden</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D19805</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/28/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Gregory Dean Mieden, FSKMC, Baltimore, MD 21224</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>3-APR-90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

34354 92

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Annie WOOLARD</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-29-90</b>  |  | 3. TIME OF DEATH<br><b>8:40AM</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>237-12-3041</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>4/9/07</b>                                  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>N.C.</b>   |  |   |  | 9a. FACILITY NAME (If not Institution, give street and number)<br><b>2121 Windsor Garden</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>                          |  |
| 9c. COUNTY OF DEATH   |  |   |  | 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |
| 10e. STREET AND NUMBER<br><b>2121 WINDSOR AVENUE</b>  |  |   |  | 10f. ZIP CODE<br><b>21207</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>            |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>Na</b> College (1-4 or 5+) <b>DOMESTIC</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOSEPH FORBES</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>UNKNOWN</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MABLE FRINK</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1602 BENTLOU STREET/BALTIMORE, MD 21216</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CEDAR HILL CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>ANNE ARUNDEL CO., MD</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Bladys Wanes</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic cardiovascular disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. SEQUENTIALLY LIST CONDITIONS, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |   |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)          |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>OCME</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-29-90</b>                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JAMES KAPLAN, MD</b>  |  |   |  | 31. DATE FILED (Month, Day, Year)<br><b>APR 2 - 1990</b>  |  |   |  |
| 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  | 33. REGISTRAR'S NAME<br><b>Julia Davidson-Rodriguez</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the cause of death permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>JOHN DANIEL WOODY   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3-12-90   |  | 3. TIME OF DEATH<br>6:18PM M   |  |
| 4. SOCIAL SECURITY NUMBER<br>218-10-6665  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>59 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>9-20-30  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>CHURCH HOME HOSPITAL  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE CITY   |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br>MD  |  |  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE CITY  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br>1807 EAST BIDDLE STREET   |  | 10f. ZIP CODE<br>21213   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) NA College (1-4 or 5+) NA                  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>UNEMPLOYED   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  | 17. FATHER'S NAME (First, Middle, Last)<br>GEORGE WOODY  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>MOLLIE HARRIS  |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br>MOLLIE WASHINGTON   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1807 EAST BIDDLE STREET/BALTIMORE, MD (13)  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>MOUNT AUBURN CEM.   |  | 20c. LOCATION — City or Town, State<br>BALTIMORE, MD   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>W. C. March  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>WM. C. MARCH F.H. 1101 E. NORTH AVE.  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE AND FATTY LIVER<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate interval between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  |  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER<br>(Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Wayne Bell   |  |  |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-13-90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARGARITA A. KORELL, MD 111 Penn Street, Baltimore, MD 21201 vc  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 2 - 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial certificate.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20-390

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Fannie L Wilson</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>25</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>5:08 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-22-3769</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>82 YRS.</b>   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2/5/08</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>VIRGINIA</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>MERCY Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>  |  |
| 9c. COUNTY OF DEATH  |  |  |  | 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>BALTIMORE</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>1619 EDMONDSON AVE</b>  |  |
| 10f. ZIP CODE  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>DOMESTIC</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>EDWARD EWELL</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ARNELIE WARREN</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>SHIRLEY STEPHENS</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>40 W. 115th STREET 10F NEW YORK, NEW YORK 10036</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>WESTERN STAR CEMETARY CATONSVILLE MD</b>  |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>CATONSVILLE MD</b>   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Berry Harris</b>   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>MARSHALL P. HAYES F.H. 638 N. Gilmer St BALTIMORE, MD 21207</b>   |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Heart Failure</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. Approximate Interval Between Onset and Death<br><b>Years</b> |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Steph F. Hqtem</b>   |  |  |  |
| 29c. LICENSE NUMBER<br><b>PENDING</b>  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/25/90</b>  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Stephen F. Hqtem</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 2 - 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Judith Davidson-Randall</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Peter Wirtz</b>   |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>30</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>12:50 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>577-54-3722</b>  |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (in yrs. last birthday)<br><b>75</b> YRS.   |  |
| 7. DATE OF BIRTH (Month, Day, Year)<br><b>4/3/14</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Germany</b>  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Mercy Medical Center</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTO MD</b>  |  | 9c. COUNTY OF DEATH<br><b>---</b>  |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>---</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE City, Md.</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>600 Light St Apt 631</b>   |  | 10f. ZIP CODE<br><b>21230</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><b>2</b> <input checked="" type="checkbox"/> Married  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>12th. Grade</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. NOT use retired.)<br><b>General Laborer</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Glass Co.</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Martin Wirtz</b>   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Katarina Surges</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. Harvey Jacob</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2361 Boston St. Balto Maryland, 21224</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Southern Mem. Gardens</b>  |  | 20c. LOCATION — City or Town, State<br><b>Dunkirk, Md.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Shane Savage</b>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Balto. Md. 21230 McCully Funeral Home. 130 E. Fort Ave.</b>  |  |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrest</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Dilated cardiomyopathy</b><br><b>Congestive heart failure</b> |  |   |  |  | Approximate Interval Between Onset and Death<br><b>50 mins</b><br><b>~ 10 yrs</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input checked="" type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> OOA<br>OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide <b>5</b> <input type="checkbox"/> Pending Investigation <b>6</b> <input type="checkbox"/> Could not be determined |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO                                   |  |
| 28d. DESCRIBE HOW INJURY OCCURED   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Mark M. Appleberry</b>   |  | 29c. LICENSE NUMBER<br><b>D02512</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/30/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Mark M. Appleberry Mercy Medical Center 301 St PAUL PLACE BALTO</b>  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 2 1990</b>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARY C. WISCOTT</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>march 31, 1990</b>  |  | 3. TIME OF DEATH<br><b>6:23 PM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-05-5977</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>1-26-08</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>NORTH ARUNDEL HOSPITAL</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>GLEN BURNIE MARYLAND</b>   |  |
| 9c. COUNTY OF DEATH<br><b>ANNE ARUNDEL</b>  |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>ANNE ARUNDEL</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>HANOVER</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>7707 RIDGE ROAD</b>   |  |
| 10f. ZIP CODE<br><b>21076</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>u.s.a.</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHN HANSELY</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>KATRINE GRUBITZ</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MILTON WISCOTT</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. BOX 128 GAMBRILLS, MD 21054</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>NEW CATHEDRAL CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROY M &amp; RUSSELL C WITZKE FUNERAL HOME<br/>1630 EDMONDSON AVE., CATONSVILLE, MD 21228</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive heart failure</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Acute myocardial infarction</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death<br><b>3 days</b> |  |  |  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Hypertension</b>   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br><b>D31122</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/1/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>KEVIN J. DOYLE, M.D. 615 HAMMONDS LANE BALTIMORE MARYLAND 21225</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 2 1990</b>  |  |  |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Pages 1, 2, & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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90 08554

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DARREN WHITING</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>25</b> YEAR <b>1990</b>  |  | 3. TIME OF DEATH<br><b>5:50AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-90-3225</b>  |  | 5. SEX<br><b>1</b> M <b>2</b> F   |  | 6. AGE (In yrs. last birthday)<br><b>27</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11/24/62</b>                     |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>UNION MEMORIAL HOSPITAL</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>               |  |
| 9c. COUNTY OF DEATH  |  |   |  |  |  |  |  |
| 10a. STATE<br><b>MARYLAND</b>  |  |   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>                       |  |
| 10d. INSIDE CITY LIMITS?<br><b>1</b> X YES <b>2</b> NO   |  |   |  |  |  |  |  |
| 10e. STREET AND NUMBER<br><b>907 Marla Drive</b>   |  |   |  | 10f. ZIP CODE<br><b>21212</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                |  |
| 11. MARITAL STATUS<br><b>1</b> X Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> X NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> YES <b>2</b> X NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b> |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>WILLIE R. BYRD</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>JEAN WHITING</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JUDY MARSHALL</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5704 FIELDVIEW CT.: BALTO. MD. 21207</b>           |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> X Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>PARKWOOD CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Leroy O. Dyett</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROY O. DYETT &amp; SON FUNERAL HOME<br/>4600 LIBERTY HEIGHTS AVENUE</b>                                       |  |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>Adult Respiratory Distress Syndrome</b><br>DUE TO (OR AS A CONSEQUENCE OF): <b>2° Heroin OD</b><br>Approximate Interval Between Onset and Death <b>11 days</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>② forearm compartment Syndrome</b><br><b>Infection / Sepsis</b>   |  |   |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> YES <b>2</b> X NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> YES <b>2</b> X NO   |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> YES <b>2</b> X NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> X Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA<br>OTHER: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |  |  |  |  |
| 27. MANNER OF DEATH<br><b>1</b> X Natural <b>5</b> Pending Investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide<br><b>4</b> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><b>1</b> YES <b>2</b> X NO                         |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Robin J. Portelli, MD</i>  |  |   |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/25/90</b>                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Robin J. Portelli One Donn Court Perry Hall, MD 21128</b>  |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 2 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be called at once.

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ITEMS:23 thru 28f per ME G-662

4-25-90 cm

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Andrew (NMI) White  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3-27-90   |  | 3. TIME OF DEATH<br>8:00PM M   |  |
| 4. SOCIAL SECURITY NUMBER<br>346-70-8255  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>20 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>APRIL 30, 1969   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>GREENOCK, SCOTLAND  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>106 Peninsula Drive   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hollywood   |  |
| 9c. COUNTY OF DEATH<br>St. MARY'S COUNTY  |  |  |  | 10a. STATE<br>MARYLAND  |  | 10b. COUNTY<br>ST. MARY'S  |  |
| 10c. CITY, TOWN OR LOCATION<br>HOLLYWOOD  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>106 PENINSULA DRIVE  |  |
| 10f. ZIP CODE<br>20636  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.K.   |  | 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>LABORER  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>CONSTRUCTION   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>WHITNEY CORNWALL WHITE   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>ANNETTE (NMN) CARROLL  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>ANNETTE CARROLL GREENE  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>106 PENINSULA DR., HOLLYWOOD, MD. 20636  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>LEE CREMOTORY   |  | 20c. LOCATION — City or Town, State<br>CLINTON, MARYLAND   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael K. Gardiner</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>MATTINGLEY-GARDINER FUNERAL HOME, P.A.<br>P.O. BOX 270, LEONARDTOWN, MARYLAND 20650   |  |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → ACUTE DARVOCET PROPOXYPHENE & ACETAMINOPHEN OVERDOSE<br>Sequently illet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>e. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>XXX YES 2 <input type="checkbox"/> NO  |  |
|   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>XXX YES 2 <input type="checkbox"/> NO   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>XXXX YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br>3-27-90                           |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED<br>SUBJECT INGESTED DARVOCET                 |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>HOME  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>106 PENINSULA DRIVE HOLLYWOOD SHORES, ST. MARYS, MD  |  |
| 29a. CERTIFIER (Check only) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Julia C. Goodin</i>   |  |  |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-28-90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>JULIA C. GOODIN, MD 111 Penn Street, Baltimore, MD 21201   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 2 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John W. Anderson</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 08556

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>GERALD MILTON WASHINGTON   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3 31 90   |  | 3. TIME OF DEATH<br>12:23 a.m.  |   |
| 4. SOCIAL SECURITY NUMBER<br>218-44-9204   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>44 yrs. YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>2/4/46   |   |
| 8a. FACILITY NAME (If not institution, give street and number)<br>VAMC, FT. HOWARD, MARYLAND 21052   |  |   |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore  |  | 8c. BIRTHPLACE (State or Foreign Country)<br>Baltimore, Md.   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>VAMC, FT. HOWARD, MARYLAND 21052   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore  |  | 9c. COUNTY OF DEATH<br>Baltimore  |   |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Baltimore City   |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>412 E. 27th St., Baltimore, Md. 21218  |  |   |  | 10f. ZIP CODE<br>21218  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>Vietnam |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No-- If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE -- American Indian, Black, White, etc.<br>Specify:<br>Black                                |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>0 - 12   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>CHEF COOK                                     |  | 16b. KIND OF BUSINESS/INDUSTRY<br>BALTIMORE CITY JAIL   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Wallace F. SMITH  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mildred Green  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>CLINICAL RECORDS   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>VA MEDICAL CENTER, FT HOWARD, MARYLAND 21052   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>METRO CREMATORY INC. 4/3/90   |  | 20c. LOCATION -- City or Town, State<br>BALTO. CATONSVILLE, MD. CO.   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Lewis T. Gwynn</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>LEWIS T. GWYNN FUNERAL HOME 21215-6393<br>4517 PARK HEIGHTS AVE. BALTIMORE, MARYLAND  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of Lung<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
| 28a. PLACE OF INJURY -- At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   | 29c. LICENSE NUMBER   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Neil Kamal MD</i>  |  |   |  |   |  |   | 29d. DATE SIGNED (Month, Day, Year)<br>3/31/90  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DR NEIL KAMAL, MD, VA MEDICAL CENTER, FT. HOWARD, MARYLAND 21052  |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>APR 2, 1990   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PEARL RHODES YOUNG</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 27, 1990</b>   |  | 3. TIME OF DEATH<br>M   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>179-03-0646</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>7/9/06</b>  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>N. Carolina</b>   |  |   |  |   |  |   |   |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><b>3003 WAYNE AVENUE (RES.)</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9c. COUNTY OF DEATH<br><b>MARYLAND</b>  |   |
| 10a. STATE<br><b>MARYLAND</b>  |  |   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>  |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |   |   |
| 10e. STREET AND NUMBER<br><b>3003 WAYNE AVENUE</b>   |  |   |  | 10f. ZIP CODE<br><b>21207</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>                      |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>RETIRED</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>GEORGE RHODES</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>PATTY WYNN</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>AQUILLA RICE</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1000 GREENHILL FARM RD. REISTERSTOWN, MD.</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MEADOW RIDGE CEMETERY</b>  |  | 20c. LOCATION — City or Town, State   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Leroy O. Dyett</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Leroy O. Dyett &amp; Son Funeral Home<br/>4600 Liberty Heights Avenue</b>  |  |   |   |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Arteriosclerotic Cardiovascular Dis.</i><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br><i>years</i>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Alzheimer's Syndrome</i>  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> ODA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Jose M. Josuico, M.D.</i>  |  |   |  | 29c. LICENSE NUMBER<br><b>013816</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-29-90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JOSE M. JOSUICO, M.D.</b>  |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 2 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Rendell</i>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 43146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other suspicious event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Rosalene E. Zimmerer   |  |  |  | 2. DATE OF DEATH<br>MONTH 5 DAY 26 YEAR 90  |  | 3. TIME OF DEATH<br>9 35 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>215-34-6177A  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>65 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>March 29, 1924  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Balto. Md.   |  |  |  | 9. FACILITY NAME (If not institution, give street and number)<br>7110 Mt. Vista Rd.   |  |  |  |
| 10. CITY, TOWN OR LOCATION OF DEATH<br>Kingsville  |  |  |  | 11. COUNTY OF DEATH<br>Baltimore  |  |  |  |
| 12a. STATE<br>Maryland   |  | 12b. COUNTY<br>Baltimore   |  | 12c. CITY, TOWN OR LOCATION<br>Kingsville   |  | 12d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 13a. STREET AND NUMBER<br>7110 Mt. Vista Rd.   |  |  |  | 13b. ZIP CODE<br>21087  |  | 13c. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 14. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 15. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 16. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 17. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |
| 18. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 yrs.  |  | 19a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Home maker   |  | 19b. KIND OF BUSINESS/INDUSTRY<br>Home  |  |  |  |
| 20. FATHER'S NAME (First, Middle, Last)<br>John G. Byer  |  |  |  | 21. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Rosa L. Snyder   |  |  |  |
| 22a. INFORMANT'S NAME (Type/Print)<br>Mr. George J. Zimmerer   |  |  |  | 22b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7110 Mt. Vista Rd. Kingsville, Md. 21087   |  |  |  |
| 23a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 23b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Parkwood Cemetery  |  | 23c. LOCATION — City or Town, State<br>Parkville, Md.   |  |  |  |
| 24. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>E. F. Lassahn   |  |  |  | 25. NAME AND ADDRESS OF FACILITY<br>E.F. Lassahn Funeral Home<br>11750 Belair Rd. Kingsville, Md. 21087   |  |  |  |
| 26. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Carcinoma of Pancreas</u><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 27a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 28a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  | 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 29. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 30. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 31. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Pending Investigation<br>3 <input type="checkbox"/> Accident 4 <input type="checkbox"/> Suicide 5 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined   |  | 32a. DATE OF INJURY (Month, Day, Year)   |  | 32b. TIME OF INJURY<br>M  |  | 32c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 33a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 33b. DESCRIBE HOW INJURY OCCURRED  |  |   |  |  |  |
| 34a. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  | 34b. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |
| 35. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 36. SIGNATURE AND TITLE OF CERTIFIER<br>Graham Fallon MD   |  |  |  | 37. LICENSE NUMBER  |  | 38. DATE SIGNED (Month, Day, Year)<br>3/27/90  |  |
| 39. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Graham Fallon, M. D. (592-2535) 11320 Cedar Lane Kingsville, Maryland   |  |  |  |   |  |  |  |
| 40. DATE FILED (Month, Day, Year)<br>APR 2 1990  |  | 41. REGISTRAR'S SIGNATURE<br>Julia K. Anderson   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 6 may be attached to the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |   |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROSA FOWLER BRIGHT</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 29 1990</b>  |  | 3. TIME OF DEATH<br><b>12:56 P</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>214-40-5130</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Feb. 22, 1907</b>                       |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Homewood South Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  | 9c. COUNTY OF DEATH  |   |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                      |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>2321 Ivy Ave.</b>   |  |  |   |
| 10f. ZIP CODE<br><b>21214</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>           |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Masters Deg.</b>   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Principal</b>  |  | 16. KIND OF BUSINESS/INDUSTRY<br><b>Baltimore City Public School</b>   |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Dennis Fowler</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rosa L. Butler</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>William Fowler</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2501 Riggs Ave. Baltimore, Maryland 21216</b>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Arbutus Memorial Park</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore County, MD</b>   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Herbert E. Nutter</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Nutter Funeral Homes, Inc.<br/>2501 Gwynns Falls Pkwy. Balto., MD 21216</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CARDIOGENIC shock AND ACUTE MYOCARDIAL INFARCT</b><br>Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  | Approximate interval between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28d. DESCRIBE NOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>D. Ansari MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D16934</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/29/90</b>                                |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J. Ansari MD - Homewood South Hospital, Baltimore MD 21218</b>  |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>J. Ansari</b>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 08560

FOR  
STATE  
REGISTRAR

Zetta Geneva Boss

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Zetta Geneva Boss</b>   |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>2</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>2 37 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220 20 2788</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS.  |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>3-12-27</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>North Carolina</b>  |  | 9. FACILITY NAME (If not institution, give street and number)<br><b>Fallston General Hospital</b>   |  |
| 10. CITY, TOWN OR LOCATION OF DEATH<br><b>Fallston</b>   |  | 11. COUNTY OF DEATH<br><b>Harford</b>  |  | 12. RESIDENCE OF DECEDENT   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Harford</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Joppa</b>   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>2400 Gilwood Road</b>   |  | 10f. ZIP CODE<br><b>21085</b>   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+)  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Waitress</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Restaurant</b>  |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>Hilary Smith</b>  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Bretta Smith</b>   |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>Darlene Bitzer</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>303 Southeastern Terrace Baltimore Maryland 21221</b>   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore County Maryland</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Bruzdinski Funeral Home PA 21221</b><br><b>1407 Old Eastern Ave Baltimore Maryland</b>  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>a. Very severe hypoxic encephalopathy</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Respiratory arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. Severe COPD / Asthma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>David C. Brick, M.D.</b>   |  | 29c. LICENSE NUMBER<br><b>D36940</b>  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>4-2-90</b>   |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br><b>DAVID BRICK, MD. FALLSTON GEN'L HOSP. FALLSTON, MD.</b>   |  | 31. DATE<br><b>APR 3 - 1990</b>   |  |
| 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reburial.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CLARA MARGARET BETTIEN</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 31, 1990</b>   |  | 3. TIME OF DEATH<br><b>4:00 A.M.</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>217-38-9232</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>July 31, 1902</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Baltimore, Md.</b>                               |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Rt. 1, Box 19 AA POPLARNECK RD.</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Preston</b>   |  | 9c. COUNTY OF DEATH<br><b>Caroline</b>  |   |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Caroline</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Preston</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>Rt. 1, Box 19 AA</b>  |  |   |  | 10f. ZIP CODE<br><b>21655</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>NA</b><br>College (1-4 or 5+) <b>NA</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Telephone Operator</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Baltimore Telephone</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Andrew Ritter</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARGARET RAUH</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Wm. John Bettien (SON)</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5521 PLAINFIELD AVE., BALTIMORE, MD. 21206</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>HOLY REDEEMER</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD.</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charles A. L...</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Schimunek Funeral H.<br/>3331 Brehms Lane, Baltimore, Md. 21213</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic Cardiovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Chronic Congestive Heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b> |  |   |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>RENAL FAILURE</b>   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |   |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>C.E. Jensen MD Deputy Med Examiner</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D14664</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/31/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>C.E. JENSEN MD, BOX 690, DENTON MD 21629</b>   |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John...</i>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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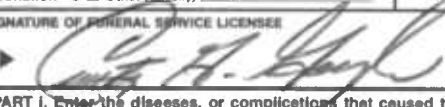

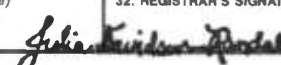
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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) (AKA BETTY M. BIANCO)<br><b>ELIZABETH M. BIANCO</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>04-02-90</b>  |  | 3. TIME OF DEATH<br><b>6 P M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>219-22-4508</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>64</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>02-08-26</b>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>W. VIRGINIA</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Stella Maris Hospice</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>   |   |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  |  | 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>---</b>  |   |
| 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>2738 BRENDAN AVENUE</b>   |   |
| 10f. ZIP CODE<br><b>21213</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>   |  |  |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>   |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>WILLIAM M. WHITTINGTON</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>NELLIE M. GROVE</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARK A. BIANCO (SON)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2738 BRENDAN AVENUE, BALTIMORE, MD. 21213</b>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MOST HOLY REDEEMER CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD.</b>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SCHIMUNEK FUNERAL HOME INC.<br/>3331 Brehms Lane, Baltimore, Md. 21213</b>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Presumed Pancreatic Carcinoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>  |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>Carla S. Alexander, M.D.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 27087</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>04-02-90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Carla S. Alexander, M.D.—Stella Maris Hospice—Dulaney Valley Rd.—Towson 21204</b>  |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

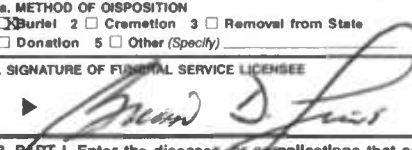

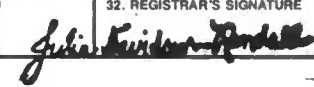
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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOANNA BONIFACE JOANNA BONIFACE</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 29 1990</b>   |  | 3. TIME OF DEATH<br><b>5:00 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-36-8557</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>49</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>SEPT. 10 1940</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>UNIVERSITY OF MARYLAND HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>  |  | 9c. COUNTY OF DEATH<br><b>MD.</b>   |  |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |   |  |
| 10a. STATE<br><b>MD.</b>  |  | 10b. COUNTY<br><b>-----</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>5820 MOORES RUN COURT</b>  |  |  |  | 10f. ZIP CODE<br><b>21206</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>n/a</b><br>College (1-4 or 5+) <b>n/a</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ROBERT BARNES</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>VIOLA GREEN</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>LARRY BONIFACE (HUSBAND)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5820 MOORES RUN COURT, BALTIMORE, MD. 21206</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GARDENS OF FAITH</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE MD.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SCHIMUNEK FUNERAL HOME INC.<br/>3331 Brehms Lane, Balto. Md. 21213</b>  |  |   |  |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PULMONARY HYPERTENSION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. <b>EISENMEYERS SYNDROME</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>PNEUMOTHORAX</b> |  |  |  |  |  |   | Approximate Interval Between Onset and Death |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/29/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>22 So. GREENE ST., BALTIMORE, MD 21201</b>  |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 08564

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CHARLES H. COATES</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>30</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>4:00 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-169834</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>68</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>07/01/21</b>  |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>HARBOR HOSPITAL CENTER 3001 S. Hanover St</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  | 10a. STATE<br><b>Md</b>  |  | 10b. COUNTY<br><b>Balto</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Balto</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>2748 Bookert Drive</b>   |  |
| 10f. ZIP CODE<br><b>21225</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input type="checkbox"/>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Civil Service U.S. Government</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Coates</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Betty Joyner</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Helen Coates</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2748 Bookert Drive Balto, Md 21225</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Garrison Forest Vet (Owings Mills, Md)</b>  |  | 20c. LOCATION — City or Town, State   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Sola March</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>March F.H. West 4300 Wabash Ave</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |   | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |  |  |   |  |
| a. <b>Cardiogenic Pulmonary Edema</b>  |  |  |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |   |  |
| b. <b>Severe Anoxic Encephalopathy</b>   |  |  |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |   |  |
| c. <b>Malignant Dysrhythmias</b>   |  |  |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |   |  |
| d. <b>NONE</b>   |  |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>NONE</b><br><b>NONE</b><br><b>NONE</b>  |  |  |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Michael D. Goldberg, M.D. Physician</b>  |  | 29c. LICENSE NUMBER<br><b>NOT LICENSED</b>  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>3/30/90</b>  |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MICHAEL D. GOLDBERG, M.D. HARBOR HOSPITAL CTR 3001 S. Hanover St Balto. MD.</b>  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>Apr 3 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Hudson-Rodell</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 08565

|   |  |  |  |   |  |   |                            |   |  |   |  |
|---|--|--|--|---|--|---|----------------------------|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>ALBERT JOSEPH CIESLAK SR.   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 30, 1990  |  | 3. TIME OF DEATH<br>12:30 A.M.  |                            |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>213-05-5886  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>75 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>OCT. 10, 1914   |                            | 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>3611 ELMORA AVE.  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |  |   | 9c. COUNTY OF DEATH<br>--- |   |  |   |  |
| RESIDENCE OF DECEDENT   |  |  |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |                            |   |  |   |  |
| 10a. STATE<br>MARYLAND  |  | 10b. COUNTY<br>---   |  | 10e. STREET AND NUMBER<br>3611 ELMORA AVENUE  |  | 10f. ZIP CODE<br>21213  |                            | 10g. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WWII  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                                    |                            |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) NA<br>College (1-4 or 5+) NA  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>KEY PUNCH DATA PROCESSOR  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>RAILROAD COMPANY  |  |   |                            |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>JOSEPH CIESLAK   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>JULIA RADOMSKI   |  |   |                            |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>JOSEPHINE CIESLAK (WIFE)  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3611 ELMORA AVE., BALTIMORE, MD. 21213   |  |   |                            |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>HOLY ROSARY CEMETERY   |  | 20c. LOCATION — City or Town, State<br>BALTIMORE, MD.   |  |   |                            |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Joseph J. Lewis</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>SCHIMUNEK FUNERAL HOMES, INC.<br>3331 BREHMS LANE, BALTIMORE, MD. 21213   |  |   |                            |   |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>e. <u>Hepatoma</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death<br><u>A month</u><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   |                            |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____<br>_____  |  |  |  |   |  |   |                            | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |                            |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |                            | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |                            |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |                            |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Charles Padgett</i><br>CHARLES PADGETT M.D.   |  |  |  |   |  | 29c. LICENSE NUMBER<br>D15546   |                            | 29d. DATE SIGNED (Month, Day, Year)<br>4-3-90   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>CHARLES PADGETT M.D. GOOD SAMARITAN HOSPITAL   |  |  |  |   |  |   |                            |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 3 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Twicken-Randall</i>   |  |   |                            |   |  |   |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Helen R. CHASE  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March 30 1990   |  | 3. TIME OF DEATH<br>7:50 pm. M   |  |
| 4. SOCIAL SECURITY NUMBER<br>215-01-8742  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>78 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>8-30-11                                    |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>FRANKLIN SQUARE HOSPITAL  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |  | 9c. COUNTY OF DEATH<br>Baltimore   |  |
| 10a. STATE<br>MARYLAND  |  |   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>520 S. LAKEWOOD AVENUE  |  |   |  | 10f. ZIP CODE<br>21224  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>8 YEARS  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>HOMEMAKER  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>MICHAEL ZAWORSKI   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>?  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>MR. RONALD CHASE  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>13522 FITZ HUGH LANE WOODBRIDGE VA. 22191  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>ST. STANISLAUS CEMETERY   |  | 20c. LOCATION — City or Town, State<br>BALTO. MD.   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Raymond H. Kaczorowski</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>KACZOROWSKI FUNERAL HOME<br>2525 FLEET ST. BALTO. MD. 21224   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Hypertension</i><br>b. <i>Dyslipidemia</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>c.<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br> |  |   |  |   |  |  | Approximate interval Between Onset and Death |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Dr. Stephen D. ...</i>  |  |   |  | 29c. LICENSE NUMBER<br>D35418   |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/2/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br>Fuller Medical Ctr. 6918 Ridge Rd. Balt, MD. 21237.   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 3 - 1990   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Gale Keidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Susan Patricia Downs</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>31</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>2:00 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220 48 2769</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F         |  | 6. AGE (In yrs. last birthday)<br><b>32</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>3-11-1958</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>University Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>   |  |
| 9c. COUNTY OF DEATH<br><b>=====</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Anne Arundel</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Linthicum</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>400 Carl Avenue</b>   |  |
| 10f. ZIP CODE<br><b>21090</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3 years</b> College (1-4 or 5+) <b>3 years</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Estimator</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Printer</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William F. Downs</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Marjorie Moore</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>M. Lorraine Webster</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>459 Mary Kay Court Linthicum, Maryland 21090</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Oaklawn Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>George J. Gonce</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>George J. Gonce Funeral Home P.A.<br/>4001 Ritchie Hwy. Baltimore, Md. 21225</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CEREBRAL HEMORRHAGE</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>THROMBOCYTOPENIA</b><br>c. <b>SINUSITIS. CARDIAC MURMUR.</b><br>d. <b>SEPSIS. GRAM POSITIVE COCCI IN CLUSTERS IN BLOOD.</b> |  |  |  |   |  |  | Approximate interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SINUSITIS. CARDIAC MURMUR.</b>  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>M. STURAITIS M.D.</b>  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>M. STURAITIS M.D. UNIV OF MARYLAND NEURO SURGEON</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED<br><b>3/31/90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. Anderson</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page II may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Donald Dodge Donald Eugene Dodge Sr.</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>April 1, 1990</i>   |  | 3. TIME OF DEATH<br><i>5:00pm</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>214-24-5164</i>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>60</i> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>4-26-29</i>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>W.Va.</i>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Church Hospital Corporation</i>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore City</i>   |  |
| 9c. COUNTY OF DEATH  |  |  |  | 10a. STATE<br><i>MD</i>  |  | 10b. COUNTY<br><i>Baltimore</i>  |  |
| 10c. CITY, TOWN OR LOCATION<br><i>Baltimore</i>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><i>2840 O'Donnell Street</i>   |  |
| 10f. ZIP CODE<br><i>21224</i>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><i>W.W. 2</i>  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>  |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>9</i> College (1-4 or 5+) <i>Self-employed</i>   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Tavern Owner</i>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Tavern Owner</i>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Robert R. Dodge</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Marian Adell</i>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Joseph E. Dodge</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>3409 O'Donnell St. Balto., Md. 21224</i>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Green Mount Crematorium</i>   |  |  |  |
| 20c. LOCATION — City or Town, State<br><i>Balto. City, Md.</i>   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charles S. Zeiler</i>  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><i>Charles S. Zeiler &amp; Son Inc. 901 S. Conkling St.</i>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Diffuse Metastatic Adenocarcinoma</i><br>a. <i>Diffuse metastatic adenocarcinoma, probably with lung primary</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Probably with lung<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br><i>M</i>  |  |  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Samir Stabshah, MD</i>   |  |  |  |
| 29c. LICENSE NUMBER<br><i>D 37366</i>  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>4/1/90</i>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Samir Stabshah, MD C/O Church Home &amp; Hosp. Corp. - Baltimore MD 21231</i>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>APR 3 1990</i>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ALFRED JAMES DREW</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>MARCH</b> DAY <b>31</b> , YEAR <b>1990</b>   |  | 3. TIME OF DEATH<br><b>5:25 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>229-18-0265</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>7/03/16</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>MARYLAND GENERAL HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>321 E. 20th STREET</b>   |  |  |  | 10f. ZIP CODE<br><b>21218</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>6th</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>LABORER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>BALTIMORE CITY</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JACKSON DREW</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARTHA DICKENSON</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>REBECCA DUNN</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>321 E. 20th STREET/BALTIMORE, MD 21218</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MOUNT AUBURN CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Gladys Wanes</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM. C. MARCH F/H 1101 E. NORTH AVENUE</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>End Stage Colon Cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>LIVER METASTASES</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>RESPIRATORY INSUFFICIENCY</b> |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>17 months</b><br><b>"</b><br><b>"</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HCN</b>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Jeremy Steinbaum MD</b>   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/31/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)<br><b>Jeremy Steinbaum c/o DEPT SURGERY, MARYLAND GENERAL HOSP, BAL</b>   |  |  |  |   |  |   |  |
| 31. DATE SIGNED (Month, Day, Year)<br><b>APR 3 - 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Gladys Wanes</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Gleawr, Dandridge</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>30</b> YEAR <b>1990</b>   |  | 3. TIME OF DEATH<br><b>6:58 PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-22-7675</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (in yrs. last birthday)<br><b>76</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>6/13/13</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Md.</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Sinai Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>                                    |  |
| 9c. COUNTY OF DEATH  |  |  |  |   |  |   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>5316 Wabash Avenue</b>  |  |  |  | 10f. ZIP CODE<br><b>21215</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:     |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Food Supervisor</b>      |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Hospital</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>George Smith</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Frances Power</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>James Dandridge</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5316 Wabash Avenue Balto., Md. 21215</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Md., National</b>   |  | 20c. LOCATION — City or Town, State<br><b>Laurel, Md.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>James A. Morton</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>James A. Morton &amp; Sons<br/>1701 Laurens Street Balto., Md. 21217</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   | Approximate interval between Onset and Death   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac failure</b>   |  |  |  |   |  |   | hours  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF): <b>Pulmonary edema</b>  |  |  |  |   |  |   | days   |
| DUE TO (OR AS A CONSEQUENCE OF): <b>Acute renal failure</b>  |  |  |  |   |  |   | days   |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | HOSPITAL:<br><input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA               |  | 26. PLACE OF DEATH (Check only one)<br>OTHER:<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Sinai Hospital</b> |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>S. Hahn, M.D.</b>  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/30/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Sinai Hospital</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 - 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Johanna Davidson-Randall</b>  |  |   |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SEKAYI FOOTMAN</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH / DAY / YEAR<br><b>3 / 29 / 1990</b>   |  | 3. TIME OF DEATH<br><b>5:30</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-25-7944</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>YRS. MONTHS DAYS HOURS MIN.<br><b>11 16</b>  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>04/13/1989</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>   |  | 9c. COUNTY OF DEATH<br><b>Maryland</b>  |  |
| RESIDENCE OF DECEDENT  |  |   |  |  |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Anne Arundel</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Severn</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>8231 Stewarton Court</b>  |  |   |  | 10f. ZIP CODE<br><b>21144</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>N/A</b><br>College (1-4 or 5+) <b>N/A</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>N/A</b>                         |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>N/A</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ANTHONY J. FOOTMAN</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>JESSIE ROBINSON</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Anthony J. Footman</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8231 Stewarton Ct., Severn, A.A. Co., MD 21144</b>                                   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>SAINT REST CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>HARMONS, A.A. CO., MD.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Herbert E. Nutter</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>NUTTER FUNERAL HOMES, INC. 21216<br/>2501 Gwynns Falls Pkwy. Baltimore, Md.</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>Cardiorespiratory arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  | Approximate Interval Between Onset and Death<br><b>10 min</b>   |  |
| Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | b. <b>Undifferentiated metastatic carcinoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  | <b>10 mos</b>   |  |
|  |  | c. <b>Massive ascites</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  | <b>10 mos</b>   |  |
|  |  | d.  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
|  |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | HOSPITAL:<br>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA                |  | 26. PLACE OF DEATH (Check only one)<br>OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                 |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|  |  | 28d. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)  |  | 28e. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>W. Smith</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D39076</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/29/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Linda Smith Reser</b>  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia L. ...</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

17522-09

17522-09



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>James H. Haven</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>04 01 90</b>  |  | 3. TIME OF DEATH<br><b>1910 M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217 26 2363</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>60</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10-23-29</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Agnes Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Balto., Md.</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Balto. City</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Baltimore County</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Woodlawn</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>5938 Baltimore Street</b>   |  |
| 10f. ZIP CODE<br><b>21207</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>12th Grade</b><br>College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Commercial Roofer</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Roofing</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Harry J. Haven</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ada S. Schach</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Roberta Haven</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5938 Baltimore Street Woodlawn, Maryland 21207</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Richard E. Davis</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>George J. Gonc Funeral Home P.A.<br/>4001 Ritchie Hwy, Baltimore, Md. 21225</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>EXSANGUINATION</b>  |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  |  |  |  |  |  |  |  |
| a. <b>COAGULOPATHY</b>   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| c. <b>MASSIVE TRANSFUSION</b>  |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| d. <b>Ruptured Abdominal Aortic Aneurysm</b>   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>hypertension</b>  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Jeffrey A. Clemens MD</b>  |  |  |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>04-01-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Jeffrey A. Clemens MD 601 N. Broadway, Baltimore, Md</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 - 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Gabe Davidson-Randall</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The death certificate may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Osceola Haliburton</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>March 31 1990</i>  |  | 3. TIME OF DEATH<br><i>4:30 PM</i>   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>216-40-9340</i>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>54</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>sept. 10, 1935</i>                      |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Virginia</i>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Beland Memorial Hospital</i>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Riverdale</i>                              |  |
| 9c. COUNTY OF DEATH<br><i>Prince George's</i>   |  |  |  | 10a. STATE<br><i>Maryland</i>   |  | 10b. COUNTY<br><i>Prince George's</i>  |  |
| 10c. CITY, TOWN OR LOCATION<br><i>College Park</i>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 10e. STREET AND NUMBER<br><i>5009 Navahoe St.</i>   |  |  |  | 10f. ZIP CODE<br><i>20740</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>                                |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>Black</i>           |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>11th</i><br>College (1-4 or 5+) <i>College</i>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Housekeeper</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Private</i>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Carey Moses Haliburton</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Gladys R. Essex</i>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Osceola G. Haliburton</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>5009 Navahoe St. College Park, Maryland 20740</i>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Harmony Memorial Park</i>   |  | 20c. LOCATION — City or Town, State<br><i>Landover, Maryland</i>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Jimmy G. Neal, Sr.</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>J.B. Jenkins Funeral Home<br/>7474 Landover Rd. Landover, Maryland 20785</i>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>CARDIO RESPIRATORY ARREST</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;">                 b. DUE TO (OR AS A CONSEQUENCE OF):<br/>                 c. DUE TO (OR AS A CONSEQUENCE OF):<br/>                 d. DUE TO (OR AS A CONSEQUENCE OF):             </div> <div style="width: 35%; border-left: 1px solid black; padding-left: 5px;">                 Approximate Interval Between Onset and Death             </div> </div> |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Metastatic BREAST Cancer</i><br><i>Renal Failure</i><br><i>Diabetes Mellitus</i>   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>A. DASHOTTAR MD</i>  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>4-1-90</i>                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>A. DASHOTTAR MD 7207 HANOVER PARKWAY A. GREENBELT MD 20771</i>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>APR 3 - 1990</i>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Gloria Davidson-Randall</i>  |  |   |  |  |  |

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1. The first part of the report is a general statement of the purpose and scope of the study.

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18. The second part of the report is a detailed description of the methods used in the study.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Joan Carol Hicks   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3-30-90   |  | 3. TIME OF DEATH<br>6:20AM M   |   |
| 4. SOCIAL SECURITY NUMBER<br>173-32-0456   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>48 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>March 6 1942 PA.                              |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>2104 Anthony Avenue  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore County   |  | 9c. COUNTY OF DEATH<br>Baltimore County  |   |
| 10a. STATE<br>Md.  |  |  |  | 10b. COUNTY<br>Baltimore  |  | 10c. CITY, TOWN OR LOCATION<br>Essex   |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |   |
| 10e. STREET AND NUMBER<br>2104 Anthony Ave.  |  |  |  | 10f. ZIP CODE<br>21221  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12)<br>10th  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Housewife   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>John Fink   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Anna Mae Oster   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Charles Wayne Hicks  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1204 Anthony Ave. Baltimore Md. 21221  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Holly Hill Cemetery  |  | 20c. LOCATION — City or Town, State<br>Balto. Md.   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Connelly Funeral Home</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>ConnellyFuneralHome300MAceAve.21221   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic cardiovascular disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Obesity  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Frank Peretti</i>  |  |  |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-30-90                                       |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>FRANK PERETTI, MD 111 Penn Street, Baltimore, MD 21201 vc   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>APR 3 - 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>BERNARD DANIEL HIEBLER  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 30, 1990   |  | 3. TIME OF DEATH<br>9:30 P.M.   |  |
| 4. SOCIAL SECURITY NUMBER<br>218-14-7725  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>81 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>AUG. 20, 1908  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>FRANCIS SCOTT KEY MEDICAL CENTER  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE   |  | 9c. COUNTY OF DEATH   |  |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |   |  |
| 10a. STATE<br>MARYLAND  |  | 10b. COUNTY<br>BALTIMORE   |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>8815 SPRING RD.   |  |  |  | 10f. ZIP CODE<br>21234   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>10   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>PAPER HANGER-SELF EMPLOYED  |  | 16b. KING OF BUSINESS/INDUSTRY   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>JOHN HIEBLER   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>NELLIE PROCTOR  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>MARYLAND B. WHALEN  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8815 SPRING RD. BALTIMORE MARYLAND 21234  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>PARKWOOD 4/3/90  |  | 20c. LOCATION — City or Town, State<br>BALTIMORE MARYLAND  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Dennis Capitano  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>BALTIMORE MD. 21214<br>LEONARD J. RUCK INC. 5305 HARFORD RD.   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Probable myocardial infarction   |  |  |  |  |  |   |  |
| b. Hypertension   |  |  |  |  |  |   |  |
| Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  |  |  |  |  |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>cerebrovascular accident  |  |  |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Susan Denman M.D.  |  |  |  | 29c. LICENSE NUMBER<br>D23584  |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/2/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Susan Denman 5200 Eastern Ave Balt Md 21224  |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 3 - 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |   |   |
|--|--|---|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Margarette C. Houpt</i>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>3-30-90</i>   |  | 3. TIME OF DEATH<br><i>4:10 P.M.</i>                                    |   |
| 4. SOCIAL SECURITY NUMBER<br><i>216-03-8967</i>  |  | 5. SEX<br><i>1 M 2 F</i>  | 6. AGE (In yrs. last birthday)<br><i>84</i> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><i>Aug 24 1905</i>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><i>Canada</i>               |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Belair Nursing Home</i>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Belair</i>   |  | 9c. COUNTY OF DEATH<br><i>Harford</i>                                   |   |
| 10a. STATE<br><i>Maryland</i>  |  |   |  | 10b. COUNTY<br><i>Harford</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>Belair</i>                            |   |
| 10d. INSIDE CITY LIMITS?<br><i>1 YES 2 NO</i>  |  |   |  |  |  |   |   |
| 10e. STREET AND NUMBER<br><i>500 Ponderosa Drive</i>   |  |   |  | 10f. ZIP CODE<br><i>21014</i>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>                   |   |
| 11. MARITAL STATUS<br><i>1 Never Married 2 Married 3 Widowed 4 Divorced</i>  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <i>1 YES 2 NO</i><br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><i>1 YES 2 NO</i> Specify:      |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i> |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 8+)   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Clerk Ret.</i>                         |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Baltimore City</i>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Pierre LaBonte</i>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Not Known</i>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Dr. William P Houpt</i>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>500 Ponderosa Drive Belair, Maryland 21014</i> |  |   |   |
| 20a. METHOD OF DISPOSITION<br><i>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</i>  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Fairview Cemetery 4/3/90</i>   |  | 20c. LOCATION — City or Town, State<br><i>Mercersburg Penna</i>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Milton J. Knight Jr.</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Leonard J. Ruck, Inc. 5305 Harford Road</i>   |  |   |   |
| 23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Sepsis</i><br>Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><i>Diabetes mellitus</i><br><i>Direct colitis, recurrent</i><br><i>Urinary Tract Infection</i> |  |   |  |  |  |   | Approximate Interval Between Onset and Death        |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Direct colitis, recurrent</i><br><i>Urinary Tract Infection</i>   |  |   |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><i>1 YES 2 NO</i> |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><i>1 YES 2 NO</i>   |  |   |  |  |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><i>1 YES 2 NO</i>  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <i>1 Inpatient 2 ER/Outpatient 3 DOA</i><br>OTHER: <i>4 Nursing Home 5 Residence 6 Other (Specify)</i> |  |  |  |   |   |
| 27. MANNER OF DEATH<br><i>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</i>  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>  |  | 28c. INJURY AT WORK?<br><i>1 YES 2 NO</i>                               |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |
| 29a. CERTIFIER (Check only one)<br><i>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i><br><i>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i>  |  |   |  |  |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Andrew Nowakowski MD</i>   |  |   |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>3/30/90</i>                   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>25 N. MAIN ST. BEL AIR, MD 21014</i>   |  |   |  |  |  |   |   |
| 31. DATE SIGNED (Month, Day, Year)<br><i>APR 3 - 1990</i>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be used to indicate the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Koralett Harrod</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>31</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>3:20PM</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-98-1001</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>32</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9/1/57</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Francis Scott Key Medical Center</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><b>MARYLAND</b>   |  |   |  | 10b. COUNTY<br><b>BALTIMORE</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>8503 GLEN MICHAELS LANE</b>  |  |   |  | 10f. ZIP CODE<br><b>21133</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JESSIE HARROD</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>RUTH GREEN</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CONSTANCE HARROD</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8503 GLEN MICHAELS LANE BALTO., MD 21133</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>WESTERN STAR CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Leroy O. Dyett</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROY O. DYETT &amp; SON FUNERAL HOME<br/>4600 LIBERTY HEIGHTS AVENUE</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pulmonary thromboembolism complicating neurofibromatosis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|   |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>David McNeill</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>OCME</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br>▶ <b>4-1-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARGARITA A. KORELL, MD 111 Penn Street, Baltimore, MD 21201</b> vc   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 - 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |   |
|---|--|--|--|--|--|--|---|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>ANNA MAE JONES</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 31 90</b>  |  | 3. TIME OF DEATH<br><b>2135 HRS M</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>083-10-7825</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>82 YRS.</b>   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan. 3, 1908</b>                           |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Liberty Medical Center</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  | 9c. COUNTY OF DEATH  |   |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                      |   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |  |  |  |   |
| 10e. STREET AND NUMBER<br><b>4002 Bateman Ave.</b>  |  |  |  | 10f. ZIP CODE<br><b>21216</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>           |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Paint Color Technician</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Rich Art Color Company</b>  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Anderson</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Cora Evans</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lucille Wiley</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4002 Bateman Ave. Baltimore, Maryland 21216</b>                                      |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore County, MD</b>   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Herbert E. Nutter</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Nutter Funeral Homes, Inc.<br/>2501 Gwynns Falls Pkwy. Balto., MD 21216</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIAC ARREST</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. <b>CHF, PULMONARY EDEMA</b><br>b. <b>PNEUMONIA</b><br>c. <b>PNEUMONIA</b><br>d. <b>PNEUMONIA</b> |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SP OVERSEW OF MALLORE WESS TEND</b>  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Carol J. Wynn</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D31300</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/31/90</b>                                |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>LIBERTY MEDICAL CTR 2600 LIBERTY HEIGHTS AVE. BALTIMORE MD 21215</b>  |  |  |  |  |  |  |   |
| 31. DATE OF DEATH   |  |  |  | 32. REGISTRAR'S SIGNATURE  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |   |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>SARAH JAY   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3 26 90  |  | 3. TIME OF DEATH<br>11 00 AM   |   |
| 4. SOCIAL SECURITY NUMBER<br>578-20-6704  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 8. AGE (In yrs. last birthday)<br>70 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>10 10 1919  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>PRINCE GEROGE HOPSITAL CENTER   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>CHEVERLY  |  | 9c. COUNTY OF DEATH<br>PRINCE GEORGE   |   |
| 10a. STATE<br>D. C.   |  |  |  | 10b. COUNTY<br>N/A   |  | 10c. CITY, TOWN OR LOCATION<br>Washington  |   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br>28th Street NW   |  | 10f. ZIP CODE<br>20001   |   |
| 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |   |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black   |  |  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Cook   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Private  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Louis Ware   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Louvenia Holmes   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>John L. Ware  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1932 Columbia Ave/Landover, Md 20785  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Maryland National  |  | 20c. LOCATION — City or Town, State<br>Laurel, Maryland  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Jimmy C. Neal, Sr.</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>J. B. Jenkins FH<br>7474 Landover Rd/Landover, Md 20785  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiac Pumping Arrest</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>Cerebral Vascular Accident</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>Hypertensive Atherosclerotic Cardiovascular Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Dissecting Aneurysm</i>  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Linda Whitby RN</i>   |  |  |  | 29c. LICENSE NUMBER<br>D17162  |  | 29d. DATE SIGNED (Month, Day, Year)<br>3/25/90   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>9556 CRAN Hwy Upper Marlboro, MD — Linda Whitby RN   |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>APR 3 - 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

2. The second part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

3. The third part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

4. The fourth part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

5. The fifth part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

6. The sixth part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

7. The seventh part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

8. The eighth part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

9. The ninth part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

10. The tenth part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".



Items 4, 11, 19a; G-662;  
4-11-90; D.R.

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FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SOLOMON RAY JOHNSON</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>1</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>10<sup>02</sup> PM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-30-5880</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>54</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>10/31/35</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>LIBERTY MEDICAL CENTER</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE CITY</b>  |  |
| 10a. STATE<br><b>MD.</b>  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>2826 Windsor Avenue</b>  |  |   |  | 10f. ZIP CODE<br><b>21216</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Driver</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Loomus</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Payton Johnson</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Frances Griffin</b>   |  |   |  |
| 19a. INFORMANT'S<br><b>Purvey Della Purney</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3125 Belmont Avenue Balto., MD. 21216</b>   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Arbutus Memorial Park</b>  |  | 20c. LOCATION — City or Town, State<br><b>Arbutus</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Dorothy Hector #281</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>E.L. Phillips Funeral Home N. Monroe St. 1721-27</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrest</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Cardiogenic Shock</b><br><b>Acute Myocardial Infarction</b> |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide |  |   |  |   |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Sher A Hashmi</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>024648</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-1-90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>SHER A HASHMI 2600 LIBERTY HEIGHTS AVE BALTIMORE 21215</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 - 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Phillip Jones</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH <i>3</i> DAY <i>23</i> YEAR <i>90</i>  |  | 3. TIME OF DEATH<br><i>6:20 A</i> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>244-01-6396</i>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>79</i> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>12/26/10</i>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Bon Secours Hospital</i>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore</i>  |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><i>Md.</i>   |  |  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><i>Baltimore</i>  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><i>819 N. Bentalou St.</i>   |  | 10f. ZIP CODE<br><i>21216</i>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  |  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>Black</i>   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Retired</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Nathaniel Jones</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Vennie Baacken</i>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Laura L. Jones</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>819 N. Bentalou St. Balto. Md. 21216</i>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Eaden Gardens</i>   |  | 20c. LOCATION — City or Town, State<br><i>Reidsville, N.C.</i>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Cecil A. Estep</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Estep Brothers Funeral Home P.A.<br/>1300 Eutaw Pl. Balto. Md. 21217</i>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardio Pulmonary Arrest</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <i>Due to (OR AS A CONSEQUENCE OF): Pulmonary Failure</i><br>b. <i>Due to (OR AS A CONSEQUENCE OF): COPD with Acute Bronchitis</i><br>c. <i>Due to (OR AS A CONSEQUENCE OF): Myocardial Infarction</i><br>d. |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Diabetes mellitus</i><br><i>Chronic Bronchitis</i>  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><i>M</i>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Heather A. [Signature]</i>   |  |  |  | 29c. LICENSE NUMBER<br><i>004432</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>3/23/90</i>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Robert M. SABUNO [Signature]</i>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>APR 3 1990</i>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 08582

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Lawrence Kuhn Lawrence Matthew Kuhn</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 1, 1990</b>  |  | 3. TIME OF DEATH<br>M<br><b>4:47 pm</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-10-2882</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>8-21-08</b>                                    |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Chruch Hospital Corporation</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 9c. COUNTY OF DEATH  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>3811 Hudson Street</b>   |  |  |  | 10f. ZIP CODE<br><b>21224</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b><br>College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Machinist</b>                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Beth. Steel</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joseph Kuhn</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Josephine Kern</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Donald J. Kuhn</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3544 Woodring Avenue Balto., Md. 21234</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Sacred Heart of Jesus Cemetery Dundalk, Md.</b>                     |  | 20c. LOCATION — City or Town, State   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Charles D. Zeller</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Charles S. Zeiler &amp; Son Inc. 6224 Eastern Ave.</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiogenic Shock</b><br>a. <b>CARDIOGENIC SHOCK</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>ASHD ASHD</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>2h</b><br><b>YAS</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>PNEUMONIA Pneumonia</b>  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO     |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)             |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Kimberly A. L. M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>DIS135</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/1/90</b>                                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>PENROPE P. SLATT MD CHURCH HOSP. 100 N. BRADWY BALTV. MD</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julie Davidson-Randall</b><br><b>21231</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 2 and 3 must be attached to the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>OSCAR KELLY</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>03</b> DAY <b>30</b> YEAR <b>90</b>   |  |   |  | 3. TIME OF DEATH<br><b>4:30 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-32-2898</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>74 YRS.</b>   |  | 7. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>12</b> YEAR <b>05</b>                            |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>NORTH CAROLINA</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>VA MEDICAL CENTER</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>FORT HOWARD</b>  |  |   |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>BALTIMORE</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>21133</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>4109 TIVERTON ROAD</b>   |  |  |  | 10f. ZIP CODE<br><b>21133</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Year or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  | 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>SECURITY</b>              |  |  |  | 17. KIND OF BUSINESS/INDUSTRY<br><b>SECURITY SERVICES</b>                                   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>EDWARD KELLY</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ANN LUCAS</b>  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CLINICAL RECORDS</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>VA MEDICAL CENTER, FORT HOWARD, MARYLAND 21052</b>   |  |   |  |  |  |
| 20. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)   |  |  |  | 20c. LOCATION — City or Town, State   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Dorothy Hector #281</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>E.L. Phillips Funeral Home N. Monroe St. 1721-27</b>  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CARCINOMA OF PROSTATE WITH METASTASIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>9 YEARS</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>OLD CVA</b><br><b>HYPERTENSION</b><br><b>CONGESTIVE HEART FAILURE</b>  |  |  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |  |  |   |  | 25. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Peter V. Juvan</b>   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>MARCH 30, 1990</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>PETER V. JUVAN, M.D. VA MEDICAL CENTER, FORT HOWARD, MD 21052</b>   |  |  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PAULINE C. Linthicum</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>28</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>12 43 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-26-5120</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9-19-1917</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>BON Secours Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><b>Md</b>  |  |  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Balto</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>713 N. Carrollton Ave</b>   |  | 10f. ZIP CODE<br><b>21217</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |  |  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                         |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Unknown</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary J. Cooper</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Sara Linthicum</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>713 N. Carrollton Ave Balto Md 21217</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>King Memorial Park</b>  |  | 20c. LOCATION — City or Town, State<br><b>Randallstown, Md</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Fortia Ebron</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>March F. H. West<br/>4300 Wabash Ave</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute myocardial infarction</b>   |  |  |  |  |  |  |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |  |  |  |  |  |  |
| b. <b>Coronary embolus</b>   |  |  |  |  |  |  |  |
| c. <b>Arteriosclerosis</b>   |  |  |  |  |  |  |  |
| d. <b>Hypertension</b>   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Rheumatoid disease</b><br><b>Chronic failure</b>  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Charles Brown</b>  |  |  |  |
| 29c. LICENSE NUMBER<br><b>D8847</b>  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/28/90</b>  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARSA S. Brown</b> <b>8840n Bay St 21217</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOSEPH J. LOMINICO</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>26</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>1:10</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>212-01-0571</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>5 8 14</b>                              |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>6606 Graceland Avenue</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH   |   |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                   |   |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>6606 Graceland Avenue</b>  |  |   |   |
| 10f. ZIP CODE<br><b>21224</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>           |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b>   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Dispatcher</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Penn Central R.R.</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Marion Lomonico</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Carmella Devito</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MS. JoAnn T. Hollinger</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3719 White Pine Rd. - Baltimore, Md. 21220</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gardens of Faith</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Md.</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Walter G. Dabrowski</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Walter G. Dabrowski</b><br><b>1005 Dundalk Ave., Balto., Md. 21224</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic renal cell carcinoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)      |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Sheldon Milner MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D18598</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/26/90</b>                             |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Sheldon Milner, MD 404 Eastern Blvd 21221</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 - 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Johia Davidson-Randall</b>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1, 2, 3 should be retained by the hospital or attending physician. Page 4 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>John Francis Lipiec</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 25 90</b>  |  | 3. TIME OF DEATH<br><b>6:45 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>537 14 0470</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (in yrs. last birthday)<br><b>66</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 18, 1924</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>   |  |  |  |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>8425 Farrell Drive</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Chevy Chase</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Chevy Chase</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>8425 Farrell Drive</b>   |  |  |  | 10f. ZIP CODE<br><b>20815</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>30 years +</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>M/Sgt.</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>United States Marine Corp.</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Frank Lipiec</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Borowicz</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Rose Marie Gillespie (sister)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as 10</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Casimir's Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Shenandoah, PA</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>David L. Lauers</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Capitol Funeral Service<br/>Falls Church, VA</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Metastatic carcinoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>Unknown</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Heidi Jolson MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D35101</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/25/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Heidi Jolson MD 5600 Fishers Lane Rockville MD MFD-733</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John J. ...</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It should be signed by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner should be notified at once.



90 08587

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |
|--|--|--|--|--|--|---|--|---|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Honorato C. Malicdem, Jr.  |  |  |  | 2. DATE OF DEATH<br>March 30, 1990   |  |   |  | 3. TIME OF DEATH<br>M   |  |  |  |   |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>221 56 5049   |  |  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>42 YRS. |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  | 7. DATE OF BIRTH<br>March 18 1948   |  | 8. BIRTHPLACE (State or Foreign Country)<br>Philippines   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>28 Freedom Court   |  |  |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Middle River   |  |  |  | 9c. COUNTY OF DEATH<br>Baltimore Co.  |  |   |  |   |  |
| 10a. STATE<br>Maryland   |  |  |  | 10b. COUNTY<br>Baltimore   |  |   |  | 10c. CITY, TOWN OR LOCATION<br>Middle River   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO           |  |   |  |   |  |
| 10e. STREET AND NUMBER<br>28 Freedom Court   |  |  |  |  |  |   |  | 10f. ZIP CODE<br>21220  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Asian  |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Inspector   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>State of Md.  |  |  |  |   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Honorato C. Malicdem  |  |  |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Rosa Campos  |  |  |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Zenaida B. Malicdem, Wife  |  |  |  |  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>28 Freedom Court Balto., Md. 21220   |  |  |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Dulaney Valley Memorial Gardens  |  |   |  | 20c. LOCATION — City or Town, State<br>Towson, Md.  |  |  |  |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  |  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Bruzdziński Funeral Home PA<br>1407 Old Eastern Ave. Balto., Md. 21221  |  |  |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC colon cancer<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. Approximate Interval Between Onset and Death<br>3 months |  |  |  |  |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>bowel obstruction  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  |   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |   |  |
|  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |   |  |   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Kenneth James Pienta M.D.  |  | 29c. LICENSE NUMBER<br>036665   |  | 29d. DATE SIGNED (Month, Day, Year)<br>04/02/90 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>KENNETH JAMES PIENTA M.D. 601 N. BROADWAY, BALTIMORE, MD 21205  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 3 - 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |   |  |  |  |   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. Pack 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |  |  |   |  |   |  |
|---|--|--|--|--|--|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ANNIE A. MITCHELL</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03-29-1990</b>  |  |  |  | 3. TIME OF DEATH<br><b>4:30 A.M.</b>   |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>578-30-3256</b>   |  |  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>68</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 12 1921</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>LIBERTY MEDICAL CENTER BALTIMORE</b>   |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>  |  |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>        |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>Baltimore City</b>   |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore City</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>1917 Eutaw Place, Apt. B 3</b>   |  |  |  |  |  | 10f. ZIP CODE<br><b>21217</b>  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Cafeteria Worker</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Government</b>   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charlie Smith</b>   |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Viola Thompson</b>   |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Helen Goldsberry</b>   |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4913 Jay Street, N.E. Apt. 31 Washington, D.C. 20019</b> |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Trinity Episcopal Church Cem.</b>   |  |  |  | 20c. LOCATION — City or Town, State<br><b>South Hill, Virginia</b>   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>NUITER FUNERAL HOMES, INC. 21216<br/>2501 GWYNNS FALLS PKWY., BALTIMORE, MD</b>                                       |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Urosepsis</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Recurrent C.V.A.</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><b>ASCVD</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |  |  |  |  | Approximate interval between Onset and Death<br><b>2 days</b>   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus</b>  |  |  |  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A. OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>AMATIUN N. NAEEM</b>   |  | 29c. LICENSE NUMBER<br><b>D15503</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/30/90</b>   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>AMATIUN N. NAEEM, 501 Delphinst Baltimore 21217</b>   |  |  |  |  |  |  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

68775 62

August 11, 1962

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HENRY MC ALLISTER</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 29 1990</b>  |  | 3. TIME OF DEATH<br><b>02:28 A<sup>M</sup></b>                                       |   |
| 4. SOCIAL SECURITY NUMBER<br><b>216-36-0320</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>50</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>June 4, 1939</b>                           |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>BALTIMORE COUNTY GENERAL HOSPITAL</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>RANDALLSTOWN</b>   |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>  |   |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                      |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |   |
| 10e. STREET AND NUMBER<br><b>3107 Betlou James Place</b>   |  |  |  | 10f. ZIP CODE<br><b>21207</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>           |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12th grade</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Assembly Line Worker</b>        |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>General Motors</b>  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Moses McAllister</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Georgeanna Gregg</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Dora McAllister</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3107 Betlou James Place Baltimore, Maryland 21207</b>                                |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <b>ENTOMBMENT</b>   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Arbutus Memorial Park</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore County, MD</b>   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Gary L. Collins</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Nutter Funeral Homes, Inc. 21216<br/>2501 GWYNNS FALLS PKWY. BALTO. MD.</b>   |  |  |   |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrest Secondary to Acute Arrhythmia</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. <b>Secondary to Some CARDIOMYOPATHY</b><br>c. <b>Due to poor Ejection Fraction</b><br>d. <b>Due to poor Ejection Fraction</b> |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>Approx- 2 Yrs.</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  | 25b. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Joseph Deckerbaum, M.D.</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D02053</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-29-90</b>                                |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Joseph Deckerbaum, M.D. 3635 OLD COURT RD. BALTO. MD. 21208</b>  |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Anderson</i>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


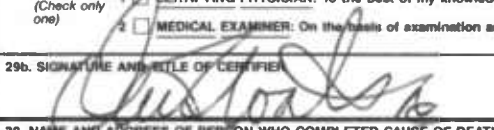
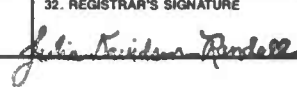
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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Helen</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 31, 1990</b>   |  |  |  | 3. TIME OF DEATH<br>p m<br><b>7:32 p m</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216 32 5434</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>YRS. <b>52</b>  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>April 19 1936</b>                       |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Franklin Sq. Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rossville</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>Baltimore County</b>  |  |
| 10a. STATE<br><b>Md.</b>  |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Essex</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>1632 Frenchs Ave.</b>  |  |  |  | 10f. ZIP CODE<br><b>21221</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>              |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>12</b><br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>   |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Walter E. Craig, Sr.</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Helen Redding</b>   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Joseph McGeeney, Son</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1826 Havre DeGrace Dr. Edgewater, Md. 21303</b>   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Memorial Gardens</b>                                 |  | 20c. LOCATION — City or Town, State<br><b>Towson Balto.Co., Md.</b>   |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Bruzdziński Funeral Home PA</b><br><b>1407 Old Eastern Ave. Balto., Md. 21221</b>  |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Electromechanical Dissociation</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Inferior Wall Myocardial Infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus</b><br><b>Hypertension</b>   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
|   |  |  |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | HOSPITAL:<br>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA             |  | 26. PLACE OF DEATH (Check only one)<br>OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                            |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                     |  | 29c. LICENSE NUMBER<br><b>N/A</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>March 31, 1990</b>                         |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dana Coates MD 9000 Franklin Square Dr. Baltimore, Md. 21237</b>  |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br>                                 |  |   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be examined by the hospital or attending physician. If the death is not natural, the certificate should be filled in by the funeral director, who should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>WALTER GATHER MCDUGAL   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March 26 1990   |  | 3. TIME OF DEATH<br>6:50 p m   |  |
| 4. SOCIAL SECURITY NUMBER<br>245-56-2210  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>51 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Sept. 29, 1938  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>North Carolina  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>MALCOLM GROW (ANDREWS AFB)   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>CAMP SPRINGS   |  | 9c. COUNTY OF DEATH<br>Prince George's   |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Prince George's   |  | 10c. CITY, TOWN OR LOCATION<br>Fort Washington  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br>2600 Brinkley Rd. #704  |  |  |  | 10f. ZIP CODE<br>20744  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th<br>College (1-4 or 5+) College   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Warehouse Receiver              |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Government  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Walter R. McDougal   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Jodie Coefield   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Thelma McDougal   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2600 Brinkley Rd. #704 Ft. Wash., MD. 20744  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Arlington Memorial Cemetery  |  | 20c. LOCATION — City or Town, State<br>Arlington, Virginia  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James C. Neal, Jr.</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>J.B. Jenkins Funeral Home<br>7474 Landover Rd. Landover, MD. 20785  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. Presumed Sepsis<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Alcohol Withdrawal<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL:<br>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Craig S. Packard</i>  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br>March 26, 1990  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>CRAIG S. PACKARD, CAPT, USAF, MC   |  |  |  | Malcolm Grow USAF Medical Center<br>Andrews AFB MD 20331-5300   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 3 - 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Thomas McCleary</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>4-1-90</i>   |  | 3. TIME OF DEATH<br><i>3:55P</i>   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>244-36-8510</i>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>62</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>May 28, 1927</i>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>North Carolina</i>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>PRINCE GEORGE'S HOSPITAL CENTER</i>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>CHEVERLY</i>   |  |
| 9c. COUNTY OF DEATH<br><i>PRINCE GEORGE'S</i>  |  |  |  | 10a. STATE<br><i>Maryland</i>   |  | 10b. COUNTY<br><i>Prince George's</i>  |  |
| 10c. CITY, TOWN OR LOCATION<br><i>Upper Marlboro</i>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><i>2716 Sandsbury Road</i>   |  |
| 10f. ZIP CODE<br><i>20772</i>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>Black</i>   |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) <i>7th</i> College (1-4 or 5+) <i></i>   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Contractor</i>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Private</i>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Randolph McClern</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Martha Hooper</i>   |  |  |  |
| 19a. INFORMANT'S NAME (Type Print)<br><i>Christine McClern</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2716 Sandsbury Rd. Upper Marlboro, Maryland 20772</i>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Washington National Cemetery</i>   |  |  |  |
| 20c. LOCATION — City or Town, State<br><i>Suitland, Maryland</i>   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Jimmy C. Neal, Jr.</i>  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><i>J.B. Jenkins Funeral Home</i><br><i>7474 Landover Rd. Landover, Maryland 20785</i>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Hypertensive cardiovascular disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i></i>  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)<br><i></i>  |  |  |  | 28b. TIME OF INJURY<br><i>M</i>   |  |  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><i></i>  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><i></i>  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><i></i>   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>August P. Rodriguez MD</i>  |  |  |  |
| 29c. LICENSE NUMBER<br><i>D-21230</i>  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>4-1-90</i>  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>August P. Rodriguez MD SDD9 Rayburn Chgo Sp. Md 20748</i>  |  |  |  | 31. DATE FILED (Month, Day, Year)<br><i>APR 3 1990</i>  |  |  |  |
| 32. REGISTRAR'S SIGNATURE<br><i>J. A. ...</i>  |  |  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the document is a list of the names of the persons who were present at the meeting. The names are listed in alphabetical order.

2. The second part of the document is a list of the topics that were discussed during the meeting. The topics are listed in alphabetical order.

3. The third part of the document is a list of the actions that were taken during the meeting. The actions are listed in alphabetical order.

4. The fourth part of the document is a list of the decisions that were made during the meeting. The decisions are listed in alphabetical order.

5. The fifth part of the document is a list of the recommendations that were made during the meeting. The recommendations are listed in alphabetical order.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>PAUL M. MADISON, Jr  |  |  |  | 2. DATE OF DEATH<br>MARCH 29 1990 YEAR  |  | 3. TIME OF DEATH<br>10:45 a.m.  |  |
| 4. SOCIAL SECURITY NUMBER<br>214-30-5132   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>56 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>9-11-1933  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>THE JOHNS HOPKINS HOSPITAL   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |  | 9c. COUNTY OF DEATH<br>BALTIMORE CITY   |  |
| 10a. STATE<br>Md   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>1107 Webb Court  |  |  |  | 10f. ZIP CODE<br>21202  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U S A  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black                                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Porter                          |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Paul M. Madison, Sr   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Louise Rainey  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Lillian L. Allen   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4053 Annellen Road Baltimore, Md 21215   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Western Star Cemetery  |  | 20c. LOCATION — City or Town, State<br>Catonsville, Md  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John March</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>March F/H West<br>4300 Wabash Avenue  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>cardiac spinal cord compression</i><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><i>metastatic lung cancer</i><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><i>3 months</i>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
|  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Eric Oshiro</i>  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3/29/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Eric Oshiro   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 3 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Henderson</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>NORA MCCRAY</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>03</b> DAY <b>28</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>1:10 PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>2-213-34-4982</b>  |  | 5. SEX<br><b>1</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>04/15/07</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Liberty Medical Center</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH<br><b>USA</b>   |  |
| 10a. STATE<br><b>Md.</b>   |  |   |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br><b>3202 Vicker Road</b>   |  | 10f. ZIP CODE<br><b>21216</b>   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  | 11. MARITAL STATUS<br><b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married<br><b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO Specify:   |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>                           |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>Richard Bennett</b>   |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Emma Bennett</b>   |  |   |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>Ruth Hall</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3421 Glen Ave. Baltimore, Md. 21215</b>         |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Arbutus Mem. Park</b>  |  | 20c. LOCATION — City or Town, State<br><b>Arbutus, Md.</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Estep Brothers Funeral Home P.A.<br/>1300 Eutaw Pl. Balto. Md. 21217</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart Failure</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br><b>Coronary Artery Disease</b><br><b>Diabetes Mellitus</b><br><br>Approximate Interval Between Onset and Death<br><b>10 minutes</b><br><b>10 years</b><br><b>30 years</b> |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>24a. WAS AN AUTOPSY PERFORMED?</b><br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO<br><br><b>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?</b><br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO   |  |   |  | 26. PLACE OF DEATH (Check only one)<br><b>HOSPITAL:</b><br><b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br><b>OTHER:</b><br><b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)   |  |   |  |
| 27. MANNER OF DEATH<br><b>1</b> <input type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide   |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  |
| 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO   |  |   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  | 29a. CERTIFIER (Check only one)<br><b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Sergio Mendez</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>M-38118</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/28/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Sergio Mendez MD Liberty Heights 2600, Balt. Md. 21215</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 - 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Arlie Nine</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>1</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>1:15 P.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-10-1041A</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (in yrs. last birthday)<br><b>80</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>5/28/9</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Ivy Hall Geriatric Center</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Balto. MD</b>   |  | 9c. COUNTY OF DEATH<br><b>Balto. Co.</b>  |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Middle River</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>553 Compass Rd.</b>   |  |   |  | 10f. ZIP CODE<br><b>21220</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>4</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Machinery Maintenance</b> |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Aero-Space</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Thomas Nine</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mabel Enlow</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mildred C. Nine, Wife</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>553 Compass Rd. Balto., Md. 21220</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Deer Park Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Deer Park Garrett Co Md</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Bruzdziński Funeral Home PA</b><br><b>1407 Old Eastern Ave. Balto., Md. 21221</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ACUTE MYOCARDIAL INFARCTION</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 26a. DATE OF INJURY (Month, Day, Year)  |  | 26b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|  |  | 26d. DESCRIBE HOW INJURY OCCURRED   |  | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |   |  | 29c. LICENSE NUMBER<br><b>D15022</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-2-90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>8552 PHILADELPHIA RD., BALTO., MD 21237</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 1990</b>   |  |   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Properly completed, this certificate may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-1-200



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CLARENCE W. OLSEN</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 30, 1990</b>   |  | 3. TIME OF DEATH<br><b>5:42A</b> M  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>191-07-1012</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>7-23-05</b>   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Memorial Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cumberland</b>  |  | 9c. COUNTY OF DEATH<br><b>Allegany</b>  |   |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |   |
| 10a. STATE<br><b>Pa.</b>  |  | 10b. COUNTY<br><b>Bedford Co.</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>RD-3 Bedford</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>RD-3</b>   |  |  |  | 10f. ZIP CODE<br><b>15522</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>10</b><br>College (1-4 or 5+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Electrician</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Steel Mill</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Olsen</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Teckla Holling</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Elsie Olsen</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>RD-3 Bedford, Pa. 15522</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Highland Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Garrett, Pa. 15542</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>William A. Price</i> <b>11249</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Price Funeral Home</b><br><b>325 Main St. Meyersdale, Pa. 15552</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Colon Carcinoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>years</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Sepsis</b>   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D33280</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/30/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Sunil K. Gupta Memorial Hospital Medical Building Cumberland, Md. 21502</b>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |   |   |  |
|---|--|--|--|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Albert PORENSKI</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 1, 1990</b>   |   | 3. TIME OF DEATH<br><b>7:45 p.m.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-03-2296</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>4/1/1912</b>   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b> |   |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><b>Franklin Square Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rossville</b>  |   | 9c. COUNTY OF DEATH<br><b>Baltimore County</b>  |  |
| 10a. STATE<br><b>Md.</b>  |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Essex</b>  |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>8 Fairway Road</b>   |  |  |  | 10f. ZIP CODE<br><b>21221</b>  |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>8th</b>   |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Security</b>  |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Martins</b>   |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Porenski</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Zuchowski</b>   |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Margaret Porenski</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8 Fairway Road Baltimore Md. 21221</b>   |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Balto. Md.</b>   |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Connelly Funeral Home</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>ConnellyFuneralHome300MAceAve.21221</b>   |   |   |  |
| 23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arteriosclerotic Cardiovascular Disease</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |   | Approximate interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Gangrene</b>   |  |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
|   |  |  |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |   | 28. DATE OF INJURY (Month, Day, Year)   |  |
|   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |   | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  | 29c. LICENSE NUMBER<br><b>N/A</b>  |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/1/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Fernando Lapetina MD. 9000 Franklin Square Drive Balto, Md. 21237</b>   |  |  |  |  |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 - 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Elsie Agnes Plodzinski</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH <i>3</i> DAY <i>31</i> YEAR <i>90</i>   |  | 3. TIME OF DEATH<br><i>1 19 A M</i>   |   |
| 4. SOCIAL SECURITY NUMBER<br><i>213-20-0554</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>64</i> YRS.  |  | 7. DATE OF BIRTH<br>Month <i>Sept.</i> Day <i>12</i> Year <i>1925</i>                       |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Fallston General Hospital</i>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Fallston</i>  |  | 9c. COUNTY OF DEATH<br><i>Harford</i>   |   |
| 10a. STATE<br><i>Md.</i>   |  |  |  | 10b. COUNTY<br><i>Harford</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>Joppa</i>   |   |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |   |
| 10e. STREET AND NUMBER<br><i>1036 Joppa Road</i>   |  |  |  | 10f. ZIP CODE<br><i>21087</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>White</i>                  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><i>7th</i>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Production Worker</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Joseph Chaney</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Anna Marshall</i>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Leona Keller</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>400 Katherine Ave. Baltimore Md. 21221</i>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Holly Hill Cemetrtery</i>   |  | 20c. LOCATION — City or Town, State<br><i>Baltimore Md.</i>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Connelly Funeral Home</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Connelly Funeral Home 300 Mace Ave. 21221</i>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiac Arrest</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>Coronary Artery Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>Generalized Atherosclerosis</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Gangrene @ Foot</i><br><i>Carotid Artery Stenosis</i>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Peter J. Solushe M.D.</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>02539</i>   |  | 29d. DATE SIGNED (Month, Day, Year)   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><i>APR 3 - 1990</i>   |  |  |  |   |  |   |   |
| 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>  |  |  |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with accuracy after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Item 1&4; G-663  
5-02-90; D.R.

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Rosean R. Pagotto  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March 30, 1990  |  |   |  | 3. TIME OF DEATH<br>M   |  |
| 4. 178-44-9241<br><del>178-54-9241</del>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>37 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Dec 30 1952 |  | 8. BIRTHPLACE (State or Foreign Country)<br>Penna.  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>4511 Powell Avenue   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |  |   |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br>Maryland   |  |  |  | 10b. COUNTY   |  |   |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore City   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br>4511 Powell Avenue  |  |   |  | 10f. ZIP CODE<br>21206  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br>United States   |  |  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  |   |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Housewife   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  | 17. FATHER'S NAME (First, Middle, Last)<br>Alphonse V. Castelli   |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Eleanore Fiorani  |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br>Stephen R. Pagotto Sr.  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4511 Powell Avenue Baltimore, Maryland 21206   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Maple Hill 4/2/90   |  |   |  | 20c. LOCATION — City or Town, State<br>Hanover Penna  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Milton J. Knight Jr.  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>21214 Leonard J. Ruck, Inc. 5305 Harford Road   |  |   |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Colorectal Cancer<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  |
| 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>G. I. Cohen M.D.   |  |   |  | 29c. LICENSE NUMBER<br>027730   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br>3/31/90   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Gary I. Cohen Baltimore, Maryland  |  |   |  | 31. DATE FILED (Month, Day, Year)<br>APR 3 - 1990   |  |
| 32. REGISTRAR'S SIGNATURE<br>John Davidson   |  |  |  |   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Teresa Carroll Quinn</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 31 1990</b>  |  | 3. TIME OF DEATH<br><b>8:17 P. M.</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>564 32 7673</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>91</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10-30-1898</b>                              |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Meridian Nursing Center</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Severna Park</b>  |  | 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>  |   |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>Anne Arundel</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Severna Park</b>                                    |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   |   |
| 10e. STREET AND NUMBER<br><b>24 Truckhouse Road</b>   |  |  |  | 10f. ZIP CODE<br><b>21146</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>            |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>12th Grade</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Beautician</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Michael Carroll</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Margaret Teresa Carroll</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Elizabeth Feusahrens</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7876 W. Riverside Drive Pasadena, Maryland 21122</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Glen Haven Memorial Park</b>  |  | 20c. LOCATION — City or Town, State<br><b>Glen Burnie, Maryland</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Donna M. Brannin</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>George J. Gonce Funeral Home P.A.<br/>4001 Ritchie Hwy. Baltimore, Md. 21225</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardio respiratory arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Cerebro vascular accident</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>H. A. S. C. V. D.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>Dementia</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate interval between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>arteriosclerosis</b>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Myrtle A. Quinn</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>022206</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4 2 90</b>                                  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>273 B. Jones Rd farm rd Annapolis Md 21012</b>  |  |  |  |   |  |   |   |
| 31. DATE FIRST SIGNED (Month, Day, Year)<br><b>APR 3 - 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Shelia Davidson-Rendell</i>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

California  
California  
H. A. C. D.  
B. A. C. D.

California  
California  
H. A. C. D.  
B. A. C. D.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>RHODA M REEL  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 30, 1990   |  | 3. TIME OF DEATH<br>3:35 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>046 09 1641  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F               |  | 6. AGE (In yrs. last birthday)<br>75 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>6-27-1914   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Canada  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>THE JOHNS HOPKINS HOSPITAL |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE   |  | 9c. COUNTY OF DEATH<br>BALTIMORE CITY  |  |
| 10a. STATE<br>Maryland  |  |  |  | 10b. COUNTY<br>=====   |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br>3615 Fairfield Road  |  | 10f. ZIP CODE<br>21226   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)                               |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Teller  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Theater  |  | 17. FATHER'S NAME (First, Middle, Last)<br>Harvey Wyle   |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Emilie Stoddard  |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br>Evelyn Smitley   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3803 - 4th Avenue Baltimore, Maryland 21225     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Meadowridge Memorial Park  |  | 20c. LOCATION — City or Town, State<br>Baltimore, Maryland   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>► Jerome Znamenski   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>George J. Gonce Funeral Home P.A.<br>4001 Ritchie Hwy. Baltimore, Md. 21225  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |  |  |  |  |  |  |
| a. Cardiac Arrest   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| b. Septicemia and septic shock  |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| c. Obstructive jaundice   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| d.  |  |  |  |  |  |  |  |
| Approximate interval Between Onset and Death<br>1 hour<br>24 hours<br>1 week  |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Coronary artery disease<br>Non insulin dependent diabetes<br>Left renal mass  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  |
| 28b. TIME OF INJURY<br>M  |  |  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>[Signature] MD   |  |  |  | 29c. LICENSE NUMBER  |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br>► 3/30/90  |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Beverly Kuch Dept Surgery, Johns Hopkins Hospital Balt MD 21205   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>3/30/93 - 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Gracie M. Rhone</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 / 30 90</b>  |  | 3. TIME OF DEATH<br><b>7 20 A M</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>212-42-8666</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>5-16-10</b>                                |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Bon Secours Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH<br><b>-</b>  |   |
| 10a. STATE<br><b>Md</b>  |  |  |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                      |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>2819 Baker St</b>  |  |  |   |
| 10f. ZIP CODE<br><b>21216</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  |  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>              |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (14 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Rudy Crisp</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Annie</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>David E. Rhone</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3100 Belmont Ave Baltimore Md 21216</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Md Nat Mem Park Laurel, Md</b>  |  | 20c. LOCATION — City or Town, State   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Portia L. Elbron</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>March Fifth West 4300 Wabash Ave</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Septic shock</b>  |  |  |  |   |  |  |   |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |  |   |
| a. <b>Staphylococcal</b>   |  |  |  |   |  |  |   |
| b. <b>Infectious, gangrenous foot</b>  |  |  |  |   |  |  |   |
| c. <b>Infectious, gangrenous foot</b>  |  |  |  |   |  |  |   |
| d. <b>Infectious, gangrenous foot</b>  |  |  |  |   |  |  |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |   |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John A. [Signature]</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D26256</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/2/90</b>                                 |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>BICH DUONG 1940 W. Baltimore St Balto Md 21223</b>   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John [Signature]</b>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Vaughn Lee Rehn  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March 30, 1990  |  | 3. TIME OF DEATH<br>10:30p M  |   |
| 4. SOCIAL SECURITY NUMBER<br>214-40-9396   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>48 RS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>March 20, 1942  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>152 East Kingston Park Lane  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore  |  | 9c. COUNTY OF DEATH<br>Baltimore  |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |   |
| 10a. STATE<br>Md.  |  | 10b. COUNTY<br>Baltimore   |  | 10c. CITY, TOWN OR LOCATION<br>Middle River   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>152 East Kingston Park Lane  |  |  |  | 10f. ZIP CODE<br>21220  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th<br>College (1-4 or 5+) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Driver  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Ralph Rehn  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Carolyn Anderson   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Sharon Rehn  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>152 East Kingston Park Lane Balto. Md. 21220   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Metro Crematory Inc.   |  | 20c. LOCATION — City or Town, State<br>Balto. Md.   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>► <i>Connolly Funeral Home</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>ConnollyFuneralHome300MaceAve.21221   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Metastatic adenocarcinoma lung.</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
|  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>N/A  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>N/A  |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |   |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>CPB Belani M.D.</i>  |  |  |  | 29c. LICENSE NUMBER<br>—  |  | 29d. DATE SIGNED (Month, Day, Year)<br>► 4/2/90   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>CHANDRA P. BELANI MD UMCC 22 S. GREENE STREET, BALTIMORE MD 21201   |  |  |  |   |  |   |   |
| 31. DATE (Month, Day, Year)<br>APR 3 - 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Anderson</i>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Property is retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MAMIE J RITZ</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 30 -1990</b>  |  | 3. TIME OF DEATH<br><b>2:30 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-14-7613</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MARCH 20, 1902</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>GREATER LAUREL NURSING HOME</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>  |  |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>   |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>- - - -</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>2715 ASHLAND AVE.</b>   |  |
| 10f. ZIP CODE<br><b>21205</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>NA</b> College (1-4 or 5+) <b>NA</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>WAITRESS</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>CATERING SERVICE</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOSEPH KLIMA</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ANTONIA SMRKA</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>LORRAINE STOLL (DAUGHTER)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7228 GARLAND AVE., TAKOMA PARK, MD. 20912</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>HOLY REDEEMER</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SCHIMUNEK FUNERAL HOMES, INC.<br/>3331 BREHMS LANE, BALTIMORE, MD. 21213</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Pneumonia</i><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Respirator</i>   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Andrew Kunkrat</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>036716</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/30/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Andrew Kunkrat 8317 CHEARY LANE, LAUREL, MD 20707</b>   |  |  |  |  |  |  |  |
| 31. DATE-FILED (Month, Day, Year)<br><b>APR 3 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. Page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |  |  |   |  |  |   |   |  |   |  |
|--|--|--|---|--|--|---|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Catherine Elizabeth Stock</i>   |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>04 01 90</i>  |  |   |  | 3. TIME OF DEATH<br><i>5:30 P.</i> M   |   |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>212-09-8376</i>  |  |  |   | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (in yrs. last birthday)<br><i>82</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>03 22 08</i>                            |   | 8. BIRTHPLACE (State or Foreign Country)<br><i>Md.</i>  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Canton Harbor Nursing Home</i>  |  |  |   |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore</i>   |  |  | 9c. COUNTY OF DEATH<br><i>City</i>                                      |   |  |   |  |
| 10a. STATE<br><i>Md.</i>   |  |  |   |  |  | 10b. COUNTY<br>-----  |  |  | 10c. CITY, TOWN OR LOCATION<br><i>Baltimore</i>                         |   |  |   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |   |  |  | 10e. STREET AND NUMBER<br><i>3903 Fait Avenue</i>   |  |  | 10f. ZIP CODE<br><i>21224</i>   |   | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i> |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i> |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>6</i> College (1-4 or 5+) -----   |  |  |   | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Housework</i>  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>At Home</i>                                     |   |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Harry Reinisch</i>   |  |  |   |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Estelle Jivinis</i>   |  |  |   |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Elizabeth Makowske</i>  |  |  |   |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>41 Holmehurst Ave. Balto., Md. 21228</i>  |  |  |   |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) -----  |  |  |   | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Sacred Heart of Jesus Cemetery Dundalk, Md.</i>   |  |   |  | 20c. LOCATION — City or Town, State  |   |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charles S. Zeiler</i>  |  |  |   |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Charles S. Zeiler &amp; Son Inc. 901 S. Conkling St.</i>   |  |  |   |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>pulmonary failure</i><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <i>pulmonary failure</i> DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>pulmonary fibrosis</i> DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |   |  |  |   |  |  |   | Approximate Interval Between Onset and Death<br><i>year</i>   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  |  |   |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide  |  |  |   | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURED  |  |   |  |
| 28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)   |  |  |   |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |  |  |   |  |  |   |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>M. Zimring MD</i>  |  |  |   |  |  | 29c. LICENSE NUMBER<br><i>015480</i>  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>4/2/90</i>                    |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>MICHAEL ZIMRING MD</i>   |  |  |   |  |  |   |  |  |   |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>APR 3 1990</i>   |  |  |   |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |  |   |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |                                       |  |  |
|---|--|--|--|---|--|---|---------------------------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>RAYMOND STONE   |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 26, 1990  |                                       | 3. TIME OF DEATH<br>10:59 p.m.   |  |
| 4. SOCIAL SECURITY NUMBER<br>247-54-6148  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>54 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>5-18-1935   |                                       | 8. BIRTHPLACE (State or Foreign Country)<br>S.C.   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>MARYLAND GENERAL HOSPITAL   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE CITY   |  |   | 9c. COUNTY OF DEATH<br>BALTIMORE CITY |  |  |
| 10a. STATE<br>Md  |  |  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |                                       | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br>2240 Linden Avenue  |  |  |  | 10f. ZIP CODE<br>21217  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U S A  |                                       |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black                                       |                                       |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>5th  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>College (1-4 or 5+)             |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |                                       |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Hardy Stone  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Corine Flowers   |  |   |                                       |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Lola Eady   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Rt 4 Box 360 Hemingway S. C. 29554   |  |   |                                       |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Arbutus Memorial Park  |  | 20c. LOCATION — City or Town, State<br>Arbutus, Md  |  |   |                                       |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Lola March</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>March F/H West<br>4300 Wabash Avenue  |  |   |                                       |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   |                                       | Approximate Interval Between Onset and Death   |  |
| a. CARCINOMA OF THE LARYNX WITH METASTASIS to LUNGS:<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |                                       | RESPIRATORY FAILURE.   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |                                       |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |                                       |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |                                       |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                       | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | HOSPITAL:<br>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA             |  | 26. PLACE OF DEATH (Check only one)<br>OTHER:<br>4 <input type="checkbox"/> Nursing Home 6 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                            |  |   |                                       |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |                                       | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                     |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Lola March</i>   |  | 29c. LICENSE NUMBER<br>N/A  |  | 29d. DATE SIGNED (Month, Day, Year)<br>3/27/90  |                                       |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>CHING Y. WONG, MD c/o MARYLAND GENERAL HOSPITAL  |  |  |  |   |  |   |                                       |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 3 1990   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia...</i>   |  |   |  |   |                                       |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Preston Simms</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 29, 1990</b>   |  | 3. TIME OF DEATH<br><b>6:00AM</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-07-8714</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>4/10/12</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Maryland General Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 9c. COUNTY OF DEATH  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>2321 E. FEDERAL STREET</b>   |  |  |  | 10f. ZIP CODE<br><b>21213</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>LABORER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>CINDERBLOCK, INC.</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JAMES SIMMS</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>JULIA</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>KATHALINE BARKSDALE</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2321 E. FEDERAL STREET/BALTIMORE, MD 21213</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MOUNT ZION CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>LANSDOWNE, MD</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Shady Wane</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM. C. MARCH F/H 1101 E. NORTH AVENUE</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Renal Failure</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Advance neurological disease</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL:<br><input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA<br>OTHER:<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Mark Davis MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D23760</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/29/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Mark Davis, M.D. c/o Maryland General Hospital</b>  |  |  |  |   |  |  |  |
| 31. DATE FILLED (Month, Day, Year)<br><b>APR 3 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |   |
|--|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Harold Sullivan</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>28</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>2:15 A.M.</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>216-10-9666</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>3-6-10</b>  |   |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Liberty Medical Center</b>  |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>   |  | 8c. COUNTY OF DEATH   |   |
| 9a. RESIDENCE OF DECEDENT  |  |  |  | 9b. CITY, TOWN OR LOCATION   |  |   |   |
| 10a. STATE<br><b>md.</b>   |  | 10b. COUNTY<br><b>—</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>1927 W. Lafayette Ave.</b>  |  |  |  | 10f. ZIP CODE<br><b>21217</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                         |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Retired</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Thomas Sullivan</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Bellzora Jenkins</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary Evans</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>307 Driver Ave. Greenville, S. Carolina 29605</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Arbutus Memorial Park</b>   |  | 20c. LOCATION — City or Town, State<br><b>Arbutus</b>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Douglas Hester #281</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>1721-27 E.L. Phillips Funeral Home N. Monroe St.</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |   | Approximate Interval Between Onset and Death  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>sepsis</b>  |  |  |  |  |  |   |   |
| a. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |   |   |
| b. DUE TO (OR AS A CONSEQUENCE OF): <b>pericardial effusion</b>  |  |  |  |  |  |   |   |
| c. DUE TO (OR AS A CONSEQUENCE OF): <b>CVA</b>   |  |  |  |  |  |   |   |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |   |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |  |  |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |   |   |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |   |
|  |  |  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |   |
|  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Khalek Al-Kabir M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>1235728</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/28/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Khalek Al-Kabir Liberty Medical Center</b>   |  |  |  |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 - 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 1314

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GEORGE SHEPLEY</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>2</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>2:07 AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>206-05-5197</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>2/10/17</b>  |  |
| 8a. RESIDENCE NAME (If not institution, give street and number)<br><b>SYKESVILLE ELDERCARE CTR</b>  |  |   |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>SYKESVILLE</b>  |  | 8c. COUNTY OF DEATH<br><b>CARROLL</b>   |  |
| 10a. STATE<br><b>Penna.</b>   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>Bethel Park</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>2408 Milford Drive</b>   |  |   |  | 10f. ZIP CODE<br><b>15102</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>W.W.II</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Retired</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Government Soc.Sec.</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>George Cieply</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Anna Zboemirsky</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>John H Shepley</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9676 Gwyn Park Drive Ellicott City 21043</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory Inc</b>  |  | 20c. LOCATION — City or Town, State<br><b>Catonsville Ms</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Harry H. Witzke</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Harry H Witzke Funeral Home Inc-<br/>4112 Old Columbia Pike ellicott City</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Intracranial pressure</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Brain astrocytoma tumor</b> |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
|   |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
|   |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Jose L. Chapulle</b>  |  |   |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/2/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JOSE L. CHAPULLE, MD. 6342 Barnett Ave. SYKESVILLE, MD.</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 - 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3145

DIVISION OF VITAL RECORDS, P.O. BOX 131

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Robert Terry</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-1-90</b>   |  | 3. TIME OF DEATH<br><b>2:46PM</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-10-8417</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>7/4/11</b>                                 |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>   |  |  |  |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>905 W. Saratoga Street</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><b>MARYLAND</b>   |  |  |  | 10b. COUNTY<br><b>BALTIMORE CITY</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>                                 |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>905 W. SARATOGA STREET</b>   |  |  |  | 10f. ZIP CODE<br><b>21223</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>           |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)  |  | 15b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHN TERRY</b>  |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>LILLIE TERRY</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CALVIN CANNON</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>909 N. COLLINGTON AVENUE BALTO, MD 21205</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ARBUTUS MEMORIAL PARK</b>   |  | 20c. LOCATION — City or Town, State<br><b>ARBUTUS, MARYLAND</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Leroy O. Dyett</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROY O. DYETT &amp; SON FUNERAL HOME<br/>4600 LIBERTY HEIGHTS AVENUE</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus</b>  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><b>INSPECTION</b> |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>XXX</b> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE NOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><b>XXXX</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Mario F. Golle, Jr.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>OCME</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-2-90</b>                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARIO F. GOLLE, JR. MD 111 Penn Street, Baltimore, MD 21221</b> vc  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 - 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randell</i>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the decedent was examined by the hospital or attending physician, the death certificate should be filled in by the attending physician and completely filled in by the funeral director. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

04289 99

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>George Tankard   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3-27-90  |  | 3. TIME OF DEATH<br>6:20PM M  |  |
| 4. SOCIAL SECURITY NUMBER<br>224-28-6170   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (in yrs. last birthday)<br>65 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>2/6/24   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>25 S. Morley Street  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City  |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br>Md.  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>25 S. Morley St.   |  |   |  | 10f. ZIP CODE<br>21229   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black                                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) Collega (1-4 or 5 +)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Retired                            |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Eddie Tankard   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Maggie Tankard  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Vickie Evans   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>203 S. Pulaski S. Balto. Md. 21223  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Western Star Cem.   |  | 20c. LOCATION — City or Town, State<br>Catonsville, Md.  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Cecil A. Estep  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Estep Brothers Funeral Home P.A.<br>1300 Eutaw Pl. Balto. Md. 21217  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arteriosclerotic cardiovascular disease and chronic alcoholism<br>Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |  |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>HEAD ONLY                                 |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/>   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Julia C. Goodin, MD   |  |   |  | 29c. LICENSE NUMBER<br>OCME  |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-28-90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>JULIA C. GOODIN, MD 111 Penn Street, Baltimore, MD 21201  |  |   |  |  |  |   |  |
| 31. DATE SIGNED (Month, Day, Year)<br>APR 3 - 1990   |  |   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |                                   |   |  |
|--|--|--|--|---|-----------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>VERONICA MANTYK</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>04</b> DAY <b>01</b> YEAR <b>90</b>  |                                   | 3. TIME OF DEATH<br><b>5 AM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>=214-03-4293</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS. | IF UNDER 1 YEAR<br>MONTHS<br>DAYS   | IF UNDER 24 HRS.<br>HOURS<br>MIN. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>09/29/13</b>   |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><b>CHURCH HOSPITAL CORPORATION</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE, Md</b>   |                                   | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>   |  |
| 10a. STATE<br><b>MD</b>  |  |  |  | 10b. COUNTY<br><b>BALTIMORE</b>   |                                   | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>919 S BINNEY STREET</b>  |                                   |   |  |
| 10f. ZIP CODE<br><b>21224</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                   |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>6 YEARS</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |                                   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHN PISKOR</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARYANNA KRUL</b>   |                                   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MR. FRANK D. MANTYK SR.</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>919 S. BINNEY ST. BALTO. MD. 21224</b>  |                                   |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ST. STANISLAUS CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTO. MD.</b>  |                                   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Raymond L. Kaczorowski</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>KACZOROWSKI FUNERAL HOME</b><br><b>2525 FLEET ST. BALTO. MD. 21224</b>   |                                   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>ABDOMINAL ABSCESS - SEPSIS</b><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>ABDOMINAL ABSCESS - SEPSIS (ENTEROCOCCUS)</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death<br><b>DAYS</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |                                   |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC LUNG DISEASE</b><br><b>CORONARY ARTERY DISEASE</b><br><b>UNDERLYING KIDNEY INSUFFICIENCY</b>  |  |  |  |   |                                   |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL:<br><input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER:<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |                                   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br><b>None</b>   |  | 28b. TIME OF INJURY<br><b>M</b>   |                                   | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 28d. PLACE OF INJURY — All home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28e. DESCRIBE HOW INJURY OCCURRED   |                                   |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |                                   |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |                                   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Robert Liberto, MD (Attending Phys.)</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D21464</b>  |                                   | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/1/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ROBERT LIBERTO, MD 3508 BANK ST BALTO, MD 21224</b>  |  |  |  |   |                                   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 - 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i> CHURCH HOSPITAL  |                                   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DOROTHY F. TINGLER</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 26, 1990</b>   |  | 3. TIME OF DEATH<br><b>2:53 PM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216 05 6023</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>8/2/10</b>                              |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>MEMORIAL HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CUMBERLAND</b>  |  | 9c. COUNTY OF DEATH<br><b>ALLEGANY</b>   |  |
| 10a. STATE<br><b>MD.</b>  |  |  |  | 10b. COUNTY<br><b>ALLEGANY</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>CCUMBERLAND</b>                                    |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>5 NORTH WAVERLY TERR.</b>  |  |  |  |
| 10f. ZIP CODE<br><b>21502</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>           |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>BEAUTICIAN</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ANDREW J. TINGLER</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY A BIRMINGHAM</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>THOMASINE CLAY (neice)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>208 Union St., Cumberland, Md. 21502</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)   |  | 20c. LOCATION — City or Town, State   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Donald S. [Signature]</i> 3-29-90   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>STATE ANATOMY BOARD, BALTO., MD. 21201</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Chronic Obstructive Lung Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>History of pneumonia, ca of heart</b> |  |  |  |   |  | Approximate interval Between Onset and Death   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-26-90</b>                                |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>R. J. BARRERA JR</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 must be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Jean E. Twardowicz</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 27, 1990</b>   |  | 3. TIME OF DEATH<br><b>8:00 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-40-5024</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>83</b>   |  | 7. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 28, 1906</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Joseph Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>  |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |
| 10a. STATE<br><b>Md.</b>  |  |  |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Towson</b>   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>2300 Dulaney Valley Road</b>   |  |  |  |
| 10f. ZIP CODE<br><b>21204</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10 College (13 or 5+)</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Teacher</b>                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Baltimore City</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Peter Twardowicz</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Valerie Tomalski</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Charlotte Kutz</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7311 Chesapeake Drive Baltimore, Md. 21219</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holy Rosary</b>   |  | 20c. LOCATION — City or Town, State<br><b>Dundalk, Maryland</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>James F. Gladden</b> <i>James F. Gladden</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Leonard J. Ruck Inc. 5305 Harford Road 21214</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Renal Failure</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>Fracture Rt Femur</b><br>c. <b>ABCD</b><br>d. <b>Fractures (Pathologic) Right Femur</b> |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>15 yrs</b><br><b>5 yrs</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Fractures (Pathologic) Right Femur</b>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>2-12-90</b>   |  | 28b. TIME OF INJURY<br><b>P M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 28d. HOW INJURY OCCURRED<br><b>Fell in Bedroom</b>  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office, building, etc. (Specify)<br><b>Stella Maris Hospice</b>                           |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>Towson Maryland</b>  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Charles F. O'Donnell</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D-9383</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>March 31, 1990</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED VALUE OF DEATH (ITEM 27) (Type, Print)<br><b>Charles F. O'Donnell</b> <b>7501 York Rd Towson Md</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Jake Davidson-Rendell</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be read by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |  |  |  |  |   |  |
|---|--|--|---|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ELLA WILLIAMS</b>  |  |  |   | 2. DATE OF DEATH<br>MONTH <b>04</b> DAY <b>02</b> YEAR <b>90</b>   |  |  |  | 3. TIME OF DEATH<br><b>7:10 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-80-914</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |   | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10 05 07</b> |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>SOUTH CAROLINA</b>                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SINAI HOSPITAL</b>   |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>  |  |  |  | 9c. COUNTY OF DEATH   |  |
| RESIDENCE OF DECEDENT   |  |  |   |  |  |  |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>BALTIMORE</b>  |   | 10c. CITY, TOWN OR LOCATION<br><b>WOODLAWN</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>3642 LOCHEARN DRIVE</b>  |  |  |   | 10f. ZIP CODE<br><b>21207</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>            |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b> |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6 YRS</b> College (1-4 or 5+) <b>DOMESTIC</b>   |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>PRIVATE FAMILIES</b> |  |  | 16b. KIND OF BUSINESS/INDUSTRY                         |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>PAUL PADGETT</b>  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>REBECCA GREEN</b>  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MRS. ELIDA BOONE</b>   |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3642 LOCHEARN DR. BALTO. MD 21207</b>  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |   | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ARBUTUS MEMORIAL PARK</b>   |  |  | 20c. LOCATION — City or Town, State<br><b>BALTO. CO., MD</b>               |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James R. Ferry, Jr.</i>   |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br><b>2501 Gwynns Falls Parkway<br/>NUTTER FUNERAL HOMES INC 21216</b>  |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardio - Resp Arrest.</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. <b>Cardiac Heart Failure.</b><br>c. <b>Aspiration Pneumonia.</b><br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>s/p long a1 bleed.</b> |  |  |   |  |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  |  |   | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M                               |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |   | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |   |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>David M. Phyl</i>   |  |  |   | 29c. LICENSE NUMBER  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-2-90</b>                       |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>RADAT JUD Phyl, INT. MED SINAI HOSPITAL</b>   |  |  |   |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 1990</b>  |  |  |   | 32. REGISTRAR'S SIGNATURE<br><i>Julia Anderson-Rodriguez</i>   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mary Witherspoon</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 29, 1990</b>  |  | 3. TIME OF DEATH<br><b>8:05PM</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-34-0045</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>53</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10/14/36</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>S.C.</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Maryland General Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>   |  |
| 9c. COUNTY OF DEATH  |  |  |  | 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>2428 Francis St.</b>  |  |
| 10f. ZIP CODE<br><b>21217</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James Jackson</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Inez Jackson</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Angela Witherspoon</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2428 Francis St. Balto. Md. 21217</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Crownsville Veteran</b>   |  | 20c. LOCATION — City or Town, State<br><b>Crownsville, Md.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Estep Brothers Funeral Home P.A.<br/>1300 Eutaw Pl. Balto. Md. 21217</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Bilateral carcinoma of the breast with metastasis to the lung and liver.</b>  |  |  |  |  |  |  |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br><b>n/a</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/30/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Haroutioun Shahinian, M.D. c/o Maryland General Hospital</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 - 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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REG. NO.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

TO THE HOSPITAL, DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |   |
|---|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Samuel ZIPKIN   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>April 1, 1990   |  | 3. TIME OF DEATH<br>1:26 a m   |   |
| 4. SOCIAL SECURITY NUMBER<br>155 03 3033  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>85 YRS.   |  | 7. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct 17 1904                                |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Franklin Sq. Hospital   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Rossville  |  | 9c. COUNTY OF DEATH<br>Baltimore Co.   |   |
| 10a. STATE<br>Maryland  |  |   |  | 10b. COUNTY<br>Baltimore  |  | 10c. CITY, TOWN OR LOCATION<br>Essex   |   |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br>5 Brett Court Apt. 117  |  |  |   |
| 10f. ZIP CODE<br>21221  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WWII |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                 |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Concessionaire                         |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Amusement   |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Aaronh Zipkin  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Bessie Borsht  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Harris T. Zipkin, Son   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8814 Philadelphia Rd. Balto. Md. 21237   |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Har Sinai Cemetery  |  | 20c. LOCATION — City or Town, State<br>Baltimore Md.  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James E. Borsht</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Cruzdzinski Funeral Home PA<br>1407 Old Eastern Ave. Balto., Md. 21221  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Strep Pneumonia<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Probable Lung Cancer<br>c.<br>d.<br>DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>  |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 26a. DATE OF INJURY (Month, Day, Year)  |  | 26b. TIME OF INJURY<br>M  |  | 26c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 26d. DESCRIBE HOW INJURY OCCURRED   |  | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Joseph Kaplan, M.D.</i>   |  |   |  | 29c. LICENSE NUMBER<br>D 35635  |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/1/90                                    |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Joseph Kaplan, M.D. 9000 Franklin Square Dr. 21237   |  |   |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>APR 3 - 1990   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. ...</i>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

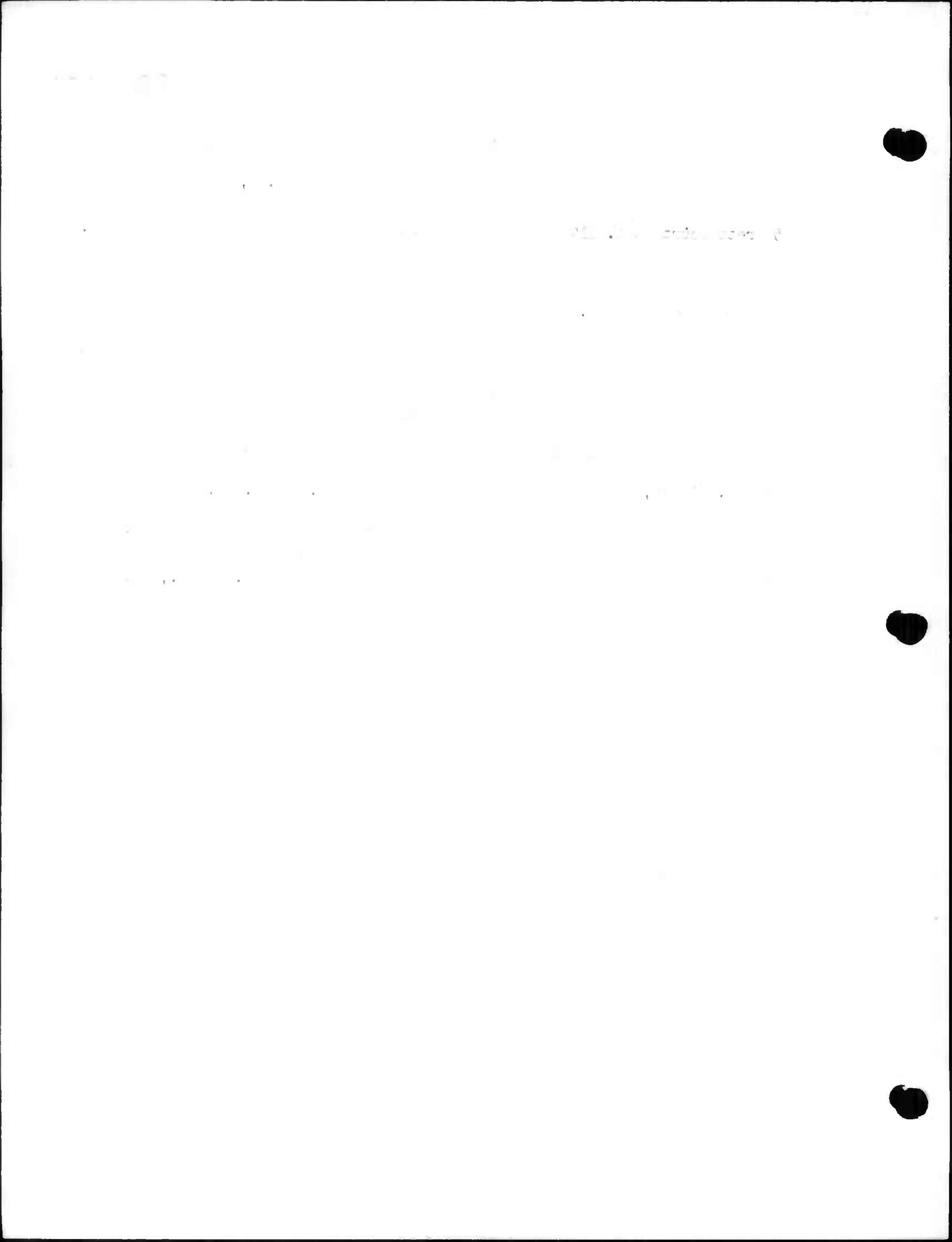
BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 8 may be retained by the hospital or attending physician.)

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90-08619

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Norman Eugene Barr</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 28 1990</b>  |  | 3. TIME OF DEATH<br>M<br><b>M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-18-0153</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>68 YRS.</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec. 6 1921</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>1813 Dunwoody Road</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Parkville</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Dorchester</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Trappe</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>P.O. Box 178</b>  |  |   |  | 10f. ZIP CODE<br><b>21673</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Letter Carrier</b>              |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Post Office</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Norman Burns Barr</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elsie Zembower</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Miriam K. Barr</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>c/o Gail Sheeler<br/>1813 Dunwoody Rd., Parkville, Md. 21234</b>                                |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Memorial Gardens</b>                                    |  | 20c. LOCATION — City or Town, State<br><b>Timonium, Md.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Bryan W. Clary</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lemmon-Mitchell-Wiedefeld<br/>Timonium, Md. 21093</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b>Metastatic large cell carcinoma - lung</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>1987</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cirrhosis of liver</b>  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <b>Stella Maris Hospice</b> |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Donald O. Wood</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D11174</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/30/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Donald O. Wood, M.D. York &amp; Greenmeadow Dr., Timonium, Md.</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION





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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MADELINE ELIZABETH BANNON</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>2</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>4:30 A.M.</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>215-46-5531</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>12/27/04</b>                               |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Meridian Nursing Home (Catonsville)</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Catonsville</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |   |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Kensington</b>                                     |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  |   |
| 10e. STREET AND NUMBER<br><b>824 Warwick Road</b>   |  |  |  | 10f. ZIP CODE<br><b>21229</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>              |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b><br>College (1-4 or 5+) <b></b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Andrew N. Hoffman</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Annie Mihm</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>John Bannon, Jr.</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>824 Warwick Road Baltimore, Maryland 21229</b>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>New Cathedral Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Raymond Peterson</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hubbard Funeral Home, Inc.<br/>4107 Wilkens Ave. Baltimore, Md. 21229</b>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Multiple Stroke Dementia</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF): <b>Alcohol-arterio vascular disease</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>3 yrs 10 mo</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
|   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Nelson McKay MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>DO 6893</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-3-90</b>                                 |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Nelson McKay 413 Commonwealth Ave. Catonsville, Md. 21228</b>   |  |  |  |   |  |  |   |
| 31. DATE OF DEATH (Month, Day, Year)<br><b>APR 4 - 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

25 4/23/72

90 08621

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Ernestine S. Bowyer  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March 31, 1990  |  | 3. TIME OF DEATH<br>6:00 p.m.   |  |
| 4. SOCIAL SECURITY NUMBER<br>215 07 9152   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>82 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>3/29/08  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>5005 St. Albans Way  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore, Md.   |  | 9c. COUNTY OF DEATH   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br>Md.  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore City   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>5005 St. Albans Way  |  |  |  | 10f. ZIP CODE<br>21212  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Charles Schmidt   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Caroline Drechsler   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mr. Charles H. Bowyer  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5005 St. Albans Way Baltimore, Md. 21212   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Loudon Park Cemetery   |  | 20c. LOCATION — City or Town, State<br>Baltimore, Md.   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>O. Sherman Denny, Jr.   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>MITCHELL-WIEDEFELD HOME, INC.<br>6500 York Road Baltimore, Md. 21212  |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ADENOCARCINOMA / UNKNOWN PRIMARY</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>2 MALIGNANT (L) PLEURAL EFFUSION</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate interval Between Onset and Death<br>2 wks  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>COPD</u><br><u>ASCVD</u><br><u>NON INSULIN DEPENDANT DIABETES MELLITUS</u>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Vincent A. DiPietro, MD   |  |  |  | 29c. LICENSE NUMBER<br>DZ8812   |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/2/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>VINCENT A. DIPETRO, MD 7801 YORK RD TOWSON MD 21204   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 4 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia [Signature]  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HELEN BOWIE</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAR. 30-90</b>   |  | 3. TIME OF DEATH<br><b>10:15P M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>216-46-3719</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>78 YRS.</b>  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>JUNE 26-11 MD.</b>                                     |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>3927 CANTERBURY ROAD</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9c. COUNTY OF DEATH   |   |
| 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>3927 CANTERBURY ROAD</b>  |  |  |  | 10f. ZIP CODE<br><b>21218</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, Specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                             |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>4</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>PHYSICIAN</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>MEDICAL</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>CLARENCE K. BOWIE</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>HELEN RICHARDSON</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>C. KEATING BOWIE</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3900 N. CHARLES ST. BALTIMORE, MD. 21218</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>LOUNDON PARK CEM.</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTO. MD. 21229</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Edison M. Perkins Jr.</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>4905 YORK ROAD 21212<br/>H.W. JENKINS AND SONS CO. BALTO. MD.</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MYOCARDIAL INFARCTION</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><div style="display: flex; justify-content: space-between;"> <div>         a. DUE TO (OR AS A CONSEQUENCE OF):<br/> <b>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</b><br/>         b. DUE TO (OR AS A CONSEQUENCE OF):<br/>         c. DUE TO (OR AS A CONSEQUENCE OF):<br/>         d.       </div> <div style="border: 1px solid black; padding: 5px;">         Approximate Interval Between Onset and Death<br/> <b>20 min.</b> </div> </div> |  |  |  |   |  |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
|  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Charles O'Donovan III</i>  |  | 29c. LICENSE NUMBER<br><b>112355</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/30/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>CHARLES O'DONOVAN III 9 EAST CHASE ST. BALTO. MD. 21202</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 08623

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARY JEANNETTE BASSETT</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>31</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>2:48 M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-18-5005</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>94</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>7/7/95</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pittsburgh, Pa</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Keswick Nursing Home</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Balto Md 21211</b>   |  |
| 9c. COUNTY OF DEATH  |  |  |  | 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY<br><b>Balto.</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Balto.</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>700 W. 40TH ST.</b>   |  |
| 10f. ZIP CODE<br><b>21211</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or "r") <b>4</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>School Teacher</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Education</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Wesley Bassett</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Cooley</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>George W. Baker</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip code)<br><b>10 Charles Plaza Balto., Md 21201</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Green Mount Crematory</b>   |  | 20c. LOCATION — City or Town, State<br><b>Balto. Md.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>John A. Slade</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>4905 York Rd.<br/>H.W. Jenkins &amp; Sons, Balto., Md 21212</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Arrest</b>  |  |  |  |  |  |  |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| b. <b>Atherosclerotic Cardiovascular Disease</b>   |  |  |  |  |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Parkinson's disease</b><br><b>Senile Dementia</b>   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Joseph W. ZEBLEY M.D.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D22334</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>31 March 1990</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Joseph W. ZEBLEY M.D. Keswick</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. Slade</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Libbye Blumberg (LIBBYE) BLUMBERG</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>30</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>4 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-07-3379</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9/6/11</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Sinai Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>636937 Reisterstown Rd</b>  |  |  |  | 10f. ZIP CODE<br><b>21215</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (14 or 5+) <b>CLERK</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>CLERK</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>SOCIAL SECURITY</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JACOB BERGER</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Last)<br><b>ETIA REBECCA SNYDE</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>SAMUEL BLUMBERG</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6937 REISTERSTOWN RD., APT. 1 BALTO., MD 21215</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>OHOB SHALOM MEM. PARK</b>   |  | 20c. LOCATION — City or Town, State<br><b>REISTERSTOWN, MD</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MI (heart attack)</b>   |  |  |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE NOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Stephen O'Neil MD</b>  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/30/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Sinai Hospital of Baltimore</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Samuel (SAMUEL) BAZEN (BAZEN)</i>   |  |   |  | 2. DATE OF DEATH<br>MONTH <i>3</i> DAY <i>29</i> YEAR <i>90</i>   |  | 3. TIME OF DEATH<br><i>12:50A M</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>213-01-5068</i>  |  | 5. SEX<br><i>XX</i> M <input type="checkbox"/> F <input type="checkbox"/> |  | 6. AGE (In yrs. last birthday)<br><i>72</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>9/17/17</i>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>PENNSYLVANIA</i>  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>BALTIMORE COUNTY GENERAL HOSPITAL</i>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>RANDALLSTOWN</i>   |  |
| 9c. COUNTY OF DEATH<br><i>BALTIMORE</i>  |  |   |  | 10a. STATE<br><i>MARYLAND</i>   |  | 10b. COUNTY<br><i>CARROLL</i>  |  |
| 10c. CITY, TOWN OR LOCATION<br><i>ELDERSBURG</i>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><i>1009 JOHNSVILLE RD.</i>   |  |
| 10f. ZIP CODE<br><i>21784</i>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>WHITE</i>  |  |   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>11</i> College (1-4 or 5+) <i></i>  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>SERVICE &amp; SALES</i>   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>APPLIANCES</i>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>MAX BAZEN</i>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>MOLLY SHIFFMAN</i>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>MRS. PEARL BAZEN</i>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1009 JOHNSVILLE RD. ELDERSBURG, MD 21784</i>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>MIKRO KODESH-BETH ISRAEL</i>   |  | 20c. LOCATION — City or Town, State<br><i>BALTIMORE, MD</i>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD. BALTO., MD 21215</i>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>metastatic Gastric Carcinoma</i><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i></i>  |  |   |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)<br><i></i>   |  | 28b. TIME OF INJURY<br><i>M</i>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><i></i>  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><i></i>  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Edmund P. Thawickas</i>  |  |   |  | 29c. LICENSE NUMBER<br><i>D34957</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>3/28/90</i>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Edmund P. Thawickas, Balt. County Health Dept.</i>   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>APR 4 1990</i>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOHN A. BRYANT</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 2, 1990</b>  |  | 3. TIME OF DEATH<br><b>7:10 P M</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>215-01-3578</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>12-28-1905</b>  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Harford Memorial Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Havre de Grace</b>   |   |
| 9c. COUNTY OF DEATH<br><b>Harford Co.</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore Co.</b>  |   |
| 10c. CITY, TOWN OR LOCATION<br><b>Perry Hall</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>26 Bangert Ave.</b>   |   |
| 10f. ZIP CODE<br><b>21128</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10 Years</b> College (1-4 or 5+) <b>-----</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Manager</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Insurance</b>   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Bryant</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mattie Whitaker</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary Etta Simpkins</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>21128 26 Bangert Ave. Perry Hall, Maryland</b>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Green Mount Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>William E. Johnson</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>William E. Johnson, P.A. Funeral Home<br/>8521 Loch Raven Blvd. Towson, MD 21204</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Respiratory failure.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. COPD - Emphysema</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. pneumomonas pneumonia.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d. Cardiac arrhythmia, vtach, Asystole</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>7 days.</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |  |   |
| 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>B. PAREKH M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D-18424</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-2-90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>B. PAREKH M.D. 1908 HARFORD RD. FALLSTON M.D. 21047</b>  |  |  |  |   |  |  |   |
| 31. DATE FILLED (Month, Day, Year)<br><b>4-1-1990</b><br>32. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b>   |  |  |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DALE MARTIN BROWN</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>31</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH <b>11:30 P M</b>                                       |  |
| 4. SOCIAL SECURITY NUMBER<br><b>236-03-3187</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>6/10/16</b>                |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>CHURCH HOSPITAL CORPORATION</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>   |  | 9c. COUNTY OF DEATH<br><b>WEST VIRGINIA</b>                             |  |
| 10a. STATE<br><b>MARYLAND</b>   |  |  |  | 10b. COUNTY<br><b>BALTIMORE</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>DUNDALK</b>                           |  |
| 10d. INSIDE CITY LIMITS<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |  |  |   |  |
| 10e. STREET AND NUMBER<br><b>2600 AMBLER RD.</b>  |  |  |  | 10f. ZIP CODE<br><b>21222</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                          |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8TH GRADE</b><br>College (1-4 or 5+) <b>N/A</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>WELDER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>BETHLEHEM STEEL CORP.</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>EMMET BROWN</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>GRACIE SWECKER</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>VIE BROWN</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2600 AMBLER ROAD BALTIMORE, MARYLAND 21222</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>OAK LAWN CEMETERY APRIL 3, 1990</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>DUDA-RUCK FUNERAL HOME OF DUNDALK, INC.<br/>7922 WISE AVENUE DUNDALK, MARYLAND 21222</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>CARDIO RESPIRATORY ARREST</b><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>Cardio respiratory Arrest</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF): <b>METASTATIC COLON CARCINOMA</b><br>b. DUE TO (OR AS A CONSEQUENCE OF): <b>Metastatic Colon Carcinoma</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
|   |  |  |  |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)                                  |  |
|   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE NOW INJURY OCCURRED                                       |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>M.D.   |  |  |  | 29c. LICENSE NUMBER<br><b>037331</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/31/90</b>                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Samir Suri M.D. Church Hospital</b>   |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br>DR. SAMIR SURI, M.D.<br>CHURCH HOSPITAL   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Harry E. Barnett  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3-31-90   |  | 3. TIME OF DEATH<br>5:27AM M   |  |
| 4. SOCIAL SECURITY NUMBER<br>217-09-8796 A  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>74 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>October 4, 1915  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Good Samaritan Hospital   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City  |  |
| 9c. COUNTY OF DEATH   |  |  |  | 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Baltimore City  |  |
| 10c. CITY, TOWN OR LOCATION<br>Baltimore City   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>3713 Ina Ave.  |  |
| 10f. ZIP CODE<br>21206  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12 yr's  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Electrician  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>William E. Barnett   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mildred I. Bates   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Nellie C. Barnett  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Same as #10  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Parkwood 4/3/90   |  | 20c. LOCATION — City or Town, State<br>Baltimore, Md.  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Paul L. Hartsock, Jr.<br><i>Paul L. Hartsock Jr.</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Baltimore, Md. 21214<br>Leonard J. Ruck, Inc. 5305 Harford Rd.  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>INQUIRY |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>XX YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>XXX Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Mario F. Golle Jr.</i>  |  |  |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>4-2-90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Mario F. Golle, Jr., MD 111 Penn Street, Baltimore, MD 21201   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 4 - 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John L. ...</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |   |
|---|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Reginald LEON Collins   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3-29-90   |  | 3. TIME OF DEATH<br>9:47PM M   |   |
| 4. SOCIAL SECURITY NUMBER<br>220-20-9139  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>59 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>06-10-30                                      |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>MD.   |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Johns Hopkins Hospital  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City                                |   |
| 9c. COUNTY OF DEATH   |  |   |  | 10a. STATE<br>MD  |  |  |   |
| 10b. COUNTY   |  |   |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE  |  |  |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br>2015 E. NORTH AVENUE  |  |  |   |
| 10f. ZIP CODE<br>21213  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |   |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>BLACK                  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12 <sup>th</sup>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>HOUSING COMM. DEVELOPEMENT   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>BALTIMORE CITY  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>CLEVELAND HARRIS   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>VIOLA COLLINS  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>VIOLA JACKSON   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2015 E. NORTH AVENUE/BALTIMORE MD 21213  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>GARRISON FOREST VET. CEM.   |  | 20c. LOCATION — City or Town, State<br>OWINGS MILLS, MD.  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Anthony E. Ward Jr.  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>WM. C. MARCH F/H 1101 E. NORTH AVENUE   |  |  |   |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypertensive arteriosclerotic cardiovascular disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Pneumonia<br>Cirrhosis  |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |   |
| 29b. SIGNATURE OF CERTIFIER   |  |   |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-30-90                                       |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>FRANK PERETTI, MD 111 Penn Street, Baltimore, MD 21201   |  |   |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>APR 4 1990   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Eula Dora Curry</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>1</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>9:45 P M</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>260-16-1631</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>06/19/07</b>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Georgia</b>   |  |  |  | 9a. FACILITY NAME (If not Institution, give street and number)<br><b>Meridian Nursing Center/Loch Raven</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Carney</b>   |   |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Baltimore</b>  |   |
| 10c. CITY, TOWN OR LOCATION<br><b>Carney</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>8720 Emge Road</b>  |   |
| 10f. ZIP CODE<br><b>21234</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Homemaker</b>   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James Franklin Key</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sara Almon</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>A. Jack Curry, Jr.</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10 Roundridge Road Timonium, Md 21093</b>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Park Hill Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Columbus, Georgia</b>  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Bryan W. Clary</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lemmon-Mitchell-Wiedefeld Inc.<br/>10 W. Padonia Road Timonium, Md 21093</b>  |  |  |   |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>stroke c @ CVA</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ASCVD</b>   |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>VU NGUYEN</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 1541X</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/2/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>VU NGUYEN, MD 1900 E 7th Rd 21234</b>  |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Anderson</b>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>EMORY G. CALTON  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3-16-90   |  | 3. TIME OF DEATH<br>6:39AM M   |  |
| 4. SOCIAL SECURITY NUMBER<br>216-22-1440   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>84 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>2-25-1906                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>St. Agnes Hospital   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |  | 9c. COUNTY OF DEATH<br>Md  |  |
| 10a. STATE<br>Md   |  |  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>Rt 2 Upper Marlboro  |  |  |  | 10f. ZIP CODE   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U S A   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)                                    |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Unknown   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Unknown  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Hollis G. Jackson  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Catonsville, Md. 21228<br>Tawes Bland Bryand N.C. Spring Grove Hosp.                               |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt Zion Cemetery   |  | 20c. LOCATION — City or Town, State<br>Lansdown, Md   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Portia Ebron  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>March F/H West<br>4300 Wabash Avenue  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>SCHIZOPHRENIA  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>XXX YES 2 <input type="checkbox"/> NO<br>PARTIAL   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>XXX YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH<br>XXX Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Frank Peretti, MD   |  |  |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-16-90                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>FRANK PERETTI, MD 111 Penn Street, Baltimore, MD 21201 VC   |  |  |  |   |  |  |  |
| 31. DATE<br>APR 4 - 1990   |  |  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |   |
|---|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Josephine NHI Conyers</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>04 02 90</i>  |  | 3. TIME OF DEATH<br><i>7:13 AM</i>  |   |
| 4. SOCIAL SECURITY NUMBER<br><i>215-24-0329</i>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>84</i> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>01/06/1906</i>  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Univ. of Maryland Hospital</i>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore City</i>   |  | 9c. COUNTY OF DEATH   |   |
| 10a. STATE<br><i>Maryland</i>   |  | 10b. COUNTY<br><i>Baltimore</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>Baltimore</i>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><i>2412 W. Edmondson Ave</i>  |  |  |  | 10f. ZIP CODE<br><i>21223</i>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>BLACK</i>                         |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (14 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Retired</i>                  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Unknown Jim Smith</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Unknown Anna Liza</i>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Mrs. Vedia Conyers</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2412 Edmondson Ave. Balto. Md. 21223</i>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Arbutus Mem. Park</i>   |  | 20c. LOCATION — City or Town, State<br><i>Balto. Co. Md.</i>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Joseph J. Russ</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Joseph L. Russ Funeral Home<br/>2222 W. North Ave. Balto. Md. 21216</i>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Septic shock</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. <i>Sepsis</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>Profound dementia</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <i>Upper gastrointestinal bleed</i> |  |  |  |  |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <i>Univ. of Maryland</i><br>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><i>M</i>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |   |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |   |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |   | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Jacquelyn L. Redd, M.D.</i>   |
| 29c. LICENSE NUMBER   |  |  |  |  |  |   | 29d. DATE SIGNED (Month, Day, Year)<br><i>4/2/90</i>  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>JACQUELYN L. REDD, M.D.</i>   |  |  |  |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><i>PR4 - 1990</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
**CERTIFICATE OF DEATH** REG. NO.

REG NO

|  |  |  |  |  |   |  |  |   |  |   |  |   |  |   |  |
|--|--|--|--|--|---|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CLAYMAN ESTHER CLAYMAN</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>03</b> DAY <b>30</b> YEAR <b>90</b>   |   |  |  | 3. TIME OF DEATH<br><b>330P</b>   |  |   |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-24-6738</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS <b>00</b> DAYS <b>00</b>   |   | IF UNDER 24 HRS.<br>HOURS <b>00</b> MIN. <b>00</b>                               |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MAY 8, 1926</b>                                       |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>   |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>UNIVERSITY HOSPITAL</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>  |   |  |  | 9c. COUNTY OF DEATH   |  |   |  |   |  |   |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |   |  |  |   |  |   |  |   |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>BALTIMORE</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>  |   |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |   |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>3401 COURTLIGH DRIVE</b>  |  |  |  | 10f. ZIP CODE<br><b>21207</b>  |   |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>usa</b>   |  |   |  |   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                         |  |   |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Second (0-12) <b>12</b> College (1-4 or 5+)  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b> |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>AT HOME</b>           |   |  |   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>NATHAN CHAIT</b>   |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>NETTIE PRESSMAN</b>   |  |  |   |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MR. ALAN CLAYMAN</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3401 COURTLIGH RD. BALTIMORE, MD 21207</b>   |   |  |  |   |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>NEW PETACH TIKVAH CONG.</b>                       |  |   |  | 20c. LOCATION — City or Town, State<br><b>ROSEDALE, MD</b> |   |  |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Joel D Lewis</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD., BALTO., MD 21215</b>  |   |  |  |   |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hypoxia</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST {<br>a. DUE TO (OR AS A CONSEQUENCE OF): <b>RIGHT PLEURAL EFFUSION</b><br>b. DUE TO (OR AS A CONSEQUENCE OF): <b>Thrombocytopenia</b><br>c. DUE TO (OR AS A CONSEQUENCE OF): <b>Acute myelogenous Leukemia</b><br>d. |  |  |  |  |   |  |  |   |  | Approximate Interval Between Onset and Death<br><b>48h</b><br><b>one week</b><br><b>one month</b><br><b>one month</b> |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |   |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                 |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 25. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |   | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |   |  |   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |   |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |   |  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>R H HUSLIG MD</b>   |  | 29c. LICENSE NUMBER<br><b>D36814</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/30/90</b> |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>R H HUSLIG MD LIMEC 225 GREENE ST. BALH.</b>   |  |  |  |  |   |  |  |   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |   |  |  |   |  |   |  |   |  |   |  |

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STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ANGELO FRANK CITARELLI</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>25</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>5:40PM</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>217105639</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>7-18-1914</b>                                      |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SACRED HEART HOSPITAL</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CUMBERLAND, MARYLAND</b>  |  | 9c. COUNTY OF DEATH<br><b>ALLEGANY</b>  |   |
| 10a. STATE<br><b>W.Va.</b>   |  | 10b. COUNTY<br><b>Mineral</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Keyser</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>305 Grand Ave.</b>  |  |   |  | 10f. ZIP CODE<br><b>26726</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>World War 11</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>10</b> College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Owner-Operator</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Royal Restaurant</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Giuseppe Citarelli</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Macalata Fameli</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Sharon Allamong</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>287 S. Mineral St. Keyser, W.Va. 26726</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Potomac Mem. Gardens</b>   |  | 20c. LOCATION — City or Town, State<br><b>Keyser, W.Va.</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Allen M. Rotruck</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Rotruck Funeral Home 85 S. Main St.<br/>Keyser, W.Va. 26726</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>UREMIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Renal failure.</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>Congestive Heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Ischemic coronary artery disease</b> |  |   |  |   |  |   | Approximate interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO           |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Samuel J. [Signature]</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>D28184</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>03/28/90</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>BALJEET MAHAL 909-B SETON DRIVE CUMBERLAND, MD 21502</b>   |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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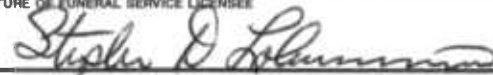
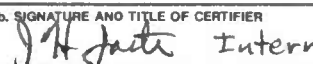

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>santos castillo (Santos Castillo)</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>1</b> YEAR <b>1990</b>   |  | 3. TIME OF DEATH<br><b>9:00 a.m.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>126 22 8042</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>1-25-1912</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Cuba</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Harbor Hospital Center</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  | 9c. COUNTY OF DEATH<br><b>Baltimore, City</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Anne Arundel</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Glen Burnie</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>7849 Crilley Rd.</b>  |  |  |  | 10f. ZIP CODE<br><b>21061</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>Cuba</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: <b>Cuban</b> |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Hispanic</b>                      |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>8</b><br>Elementary/Secondary (0-12)   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Interior Decorator</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Department Store</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Santos Castillo</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rojelia Dominguez</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Annette Allender</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>244 Keith Ct., Millersville, MD 21108</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>   |  | 20c. LOCATION — City or Town, State<br><b>Catonsville, MD</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>McCully Funeral Home of Pasadena<br/>3204 Mountain Rd., Pasadena, MD 21122</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |  |  |   |  |
| a. <b>hepatic encephalopathy</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |   |  |
| b. <b>GI bleeding</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |   |  |
| c. <b>renal failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |   |  |
| d. _____   |  |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br><b>Yes, requested</b>   |  |  |  |  |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br> <b>Intern</b>   |  |  |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-1-90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J.H. Jaster 3001 S. Hanover St. Baltimore, Md. 21230</b>   |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

25000000





90 08636

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>LARENE IDA DAILEY  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 29, 1990   |  | 3. TIME OF DEATH<br>4:05 P. M.   |   |
| 4. SOCIAL SECURITY NUMBER<br>169-18-1638   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>69 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Aug. 15, 1924  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Pennsylvania   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>G.B.M.C. 6701 N. Charles St.   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Towson  |   |
| 9c. COUNTY OF DEATH<br>Baltimore   |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Baltimore   |   |
| 10c. CITY, TOWN OR LOCATION<br>Cockeysville  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>103 16C Malcolm Circle   |   |
| 10f. ZIP CODE<br>21093   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WW II   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12 Years  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Home   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Luther R. Plath   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Marion Weidner  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>George A. Dailey   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 31, Cockeysville, Md. 21030  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)   |  | 20c. LOCATION — City or Town, State  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James F. Burnside, Jr.</i><br>James F. Burnside, Jr.   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Mitchell-Wiedefeld Home, Inc.<br>6500 York Rd. Baltimore, Md. 12121  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. Cardiopulmonary arrest<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Sepsis, Gangrene<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. DM, Alzhiemer<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Diabetes   |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL:<br>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Paul M. Rivas</i><br>Paul M. Rivas, M.D.   |  |  |  | 29c. LICENSE NUMBER<br>D 25488   |  | 29d. DATE SIGNED (Month, Day, Year)<br>March 30, 1990  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Paul M. Rivas, M.D. 3421 Sweetair Rd. Pnoenix, Md. 21131  |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>APR 4 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Juli Burdon-Rodell</i>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 08637

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Allen Datcher</b>   |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>1</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>12:10 P.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>24-12-2725</b>   |  | 6. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Sina, Hospital of Baltimore</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  |
| 10e. STREET AND NUMBER<br><b>4800 Selan Drive</b>  |  | 10f. ZIP CODE<br><b>21215</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII Army</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>(12)</b> College (1-4 or 5+)   |  | 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>LABOR</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Datcher</b>  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>LAVINIA MCGRAW DATCHER</b>  |  | 19. KIND OF BUSINESS/INDUSTRY<br><b>POST OFFICE</b>  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>NINA DATCHER</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>109 S. EXETER ST. APT 24 BALT. MD 21202</b>   |  | 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |
| 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GARRISON FOREST VIA CEM.</b>  |  | 20c. LOCATION — City or Town, State<br><b>OWINGS MILLS MD.</b>  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Betta Funeral Home</b>   |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>1129 N. CAROLINE ST BALT MD</b>   |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ventricular Tachycardia</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>4/1/90</b>  |  |
| 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Stephen O'Neil MD</b>  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/1/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Stephen O'Neil MD Sina, Hospital of Baltimore</b>  |  | 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Juli Anderson-Russell</b>  |  |

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90 08638

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Bernadette T. Dawson   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>03 28 1990  |  | 3. TIME OF DEATH<br>8:25 A M   |  |
| 4. SOCIAL SECURITY NUMBER<br>190-24-3650   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>70 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>May 6, 1919   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Washington   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Lions Manor Nurshing Home   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Cumberland  |  |
| 9c. COUNTY OF DEATH<br>Allegany  |  |  |  | 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Allegany  |  |
| 10c. CITY, TOWN OR LOCATION<br>Cumberland  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>916 Eastgate Court   |  |
| 10f. ZIP CODE<br>21502   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)<br>12  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Home Maker  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Howard Trevorrow  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Leora Berkey   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Joseph Dawson  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>916 Eastgate Court Cumberland MD 21502   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Union Cemetery  |  | 20c. LOCATION — City or Town, State<br>Somerset PA   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Edward R. Zeigler</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Hauger-Zeigler Funeral Home Somerset PA   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute Respiratory Infection</i><br>Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF): <i>Pneumonia</i><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Pneumonia R Femur</i><br><i>CVA Dementia</i><br><i>ASCOB COP</i>  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Dr. Mazzocco</i>   |  |  |  | 29c. LICENSE NUMBER<br>D07135 m   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-28-90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>VE MAZZOCCO 912 Seton Drive, Cumberland, MD. 21502  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>3/28/90   |  | 32. REGISTRAR'S SIGNATURE<br><i>Johanna Davidson-Randall</i>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOHN E. FLANAGAN</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>04</b> DAY <b>02</b> YEAR <b>1990</b>   |  | 3. TIME OF DEATH<br><b>12:00 PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-05-9322</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10/03/1905</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MISSISSIPPI</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>G.B.M.C. 6701 N. CHARLES STREET</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>TOWSON</b>   |  |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>BALTIMORE</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>HUNT VALLEY</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>300 INTERNATIONAL CIRCLE</b>  |  |
| 10f. ZIP CODE<br><b>21030</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1923</b>  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 Years</b><br>College (1-4 or 5+) _____  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Instructor</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>MTA</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>FLANAGAN, EVANDER</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary SMITH</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Janice Hoddinott</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6229 Oak Hill Drive Eldersburg, Maryland 21784</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Lake View Memorial Park</b>   |  | 20c. LOCATION — City or Town, State<br><b>Sykesville, Maryland</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>James F. Burnside, Jr.</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Mitchell-Wiedefeld Home, Inc.<br/>6500 York Rd. Baltimore, Md. 21212</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>COPD</b><br>c. <b>Smoking</b><br>d. _____ |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____<br>_____   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>_____  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br>_____   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>_____  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>_____  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Paul M. Rivas</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D25488</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/3/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>PAUL M. RIVAS, M.D. 300 International Circle Cockeysville, Md. 21030</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John H. Anderson</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HILDA R. GROTE</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>1</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>1035p</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>205-165077</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>4/28/26</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Good Samaritan Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Overlea</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>3016 Chesley Avenue</b>  |  |  |  | 10f. ZIP CODE<br><b>21234</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>11th grade</b><br>College (1-4 or 5+) <b></b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Homemaking</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James Monroe Weaver</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Vernie Bailey</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Charles Grote</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3016 Chesley Ave. Baltimore, Maryland 21234</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Jacob's Stone Church Cem.</b>   |  | 20c. LOCATION — City or Town, State<br><b>Brodbecks, Penna.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Lassahn Funeral Home Inc.</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lassahn Funeral Hom</b><br><b>7401 Belair Rd. Balto., Md. 21236</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>HYDRONEPHROSIS BILATERAL 2°</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>METASTATIC COLON CA</b><br>c. <b></b><br>d. <b></b> |  |  |  |   |  | Approximate interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
|   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
|   |  | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
|   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Joseph Quist MD</i>   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/1/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JOSEPH QUIST MD GOOD SAMARITAN HOSP 5601 LUCHRAVEN BLVD</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>David Franklin Griffin</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>2</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>1450 P</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>237-62-3576</b>   |  | 5. SEX<br><b>1</b> <input type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>96</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>5/11/93</b>  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>N.C.</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Agnes Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>                                       |   |
| 9c. COUNTY OF DEATH   |  |  |  |   |  |  |   |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |   |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>CATONSVILLE</b>   |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input type="checkbox"/> YES <input type="checkbox"/> NO      |   |
| 10e. STREET AND NUMBER<br><b>5901 Johnson ST</b>  |  |  |  | 10f. ZIP CODE<br><b>21228</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 11. MARITAL STATUS<br><b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>                         |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Retired</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>WARREN Griffin</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>AMANDA Peel</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. John Griffin</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5901 Johnson St Catonsville Md. 21228</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MANSON Church Cem.</b>   |  | 20c. LOCATION — City or Town, State<br><b>Williamstown, N.C.</b>                                   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Joseph L. Russ</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Joseph L. Russ Funeral Home<br/>2222 W. North Ave. Baltimore, Md. 21224</b>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Antisclerotic Cardiovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO  |
|   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. MANNER OF DEATH<br><b>1</b> <input type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending investigation<br><b>2</b> <input type="checkbox"/> Accident<br><b>3</b> <input type="checkbox"/> Suicide <b>6</b> <input type="checkbox"/> Could not be determined<br><b>4</b> <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |   |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>R. Girp MD</b>  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-2-90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Raafat Y. Girgis 500 N. Rolling Rd. Catonsville</b>   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Pandell</b>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DORA GOLDGEIER</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 29 90</b>   |  | 3. TIME OF DEATH<br><b>2:33 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-40-1655</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>JAN. 26, 1905</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SINAI HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><b>MARYLAND</b>  |  |  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>3601 FORDS LA., APT. 306</b>   |  | 10f. ZIP CODE<br><b>21215</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>12</b> College (1-4 or 5+) <b>HOUSEWIFE</b>   |  |  |  | 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b>  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>AT HOME</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>MORRIS EDELMAN</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>SARAH UNKNOWN GOLDEN</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>DR. SHELDON GOLDGEIER</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2314 SUGAR CONE RD. BALTIMORE, MD 21209</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>WORKMEN CIRCLE</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>A. ADULT RESPIRATORY DISTRESS SYNDROME</b>  |  |  |  |   |  |  |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28b. DESCRIBE NOW INJURY OCCURRED   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>CTLUNGA</b>   |  |  |  |
| 29c. LICENSE NUMBER  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3.29.1990</b>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>SINAI HOSPITAL OF BALTIMORE</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>E Anna F. Grasser</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>3</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>4:45 A M</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>212-03-9267</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>5-10-12</b>  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Sicily</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Good Samaritan Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>   |   |
| 9c. COUNTY OF DEATH  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY  |   |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore City</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>3508 E. Northern Parkway</b>  |   |
| 10f. ZIP CODE<br><b>21206</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>10th grade</b> College (1-4 or 5+) <b>College</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Seamstress</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Lebow Brothers</b>  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Franeesco Carini</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Josephine Delloglio</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JoAnne Chapolini</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3105 Bennington Court Baldwin, Md. 557-6815</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Most Holy Redeemer Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Balto., City, Md.</b>  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Lassahn Funeral Home</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lassahn Funeral Home</b><br><b>7401 Belair Rd. Balto., Md. 21236</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. <b>Ruptured bowel perforation</b><br>c.<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>COPD</b> |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>10 hrs</b> |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |   |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Howard Staudenmaier MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>01</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/3/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>5601 Loch Raven Blvd Balto Md 21239</b>  |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Anderson-Randell</b>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GEORGE CARROLL GIBSON</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>2</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>5:30 P</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-05-4122</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec. 7, 1908</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Crofton Convalescent Center</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Crofton, Maryland</b>  |  |
| 9c. COUNTY OF DEATH<br><b>A.A.Co.</b>   |  |  |  | 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY<br><b>-----</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Balto. City, Md.</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>11 W. Randall St.</b>   |  |
| 10f. ZIP CODE<br><b>21230</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th. grade</b><br>College (14 or 5+) <b>-----</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Yardmaster</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>B.&amp;.O. Railroad</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William ----- Gibson</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Florence --- Stecker</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Ella B. Gibson</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11 W. Randall St. balto. Md. 21230</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>New Cathedral Cemt.</b>   |  | 20c. LOCATION — City or Town, State<br><b>Balto. Md.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Med. A. Bishop</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>21230 Balto. Md.<br/>McCully Funeral Home, 130 E. Fort Ave</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Left ventricular failure</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <b>Myo-infarct</b><br>b. <b>Dementia</b><br>c. <b>-----</b><br>d. <b>-----</b><br>Approximate Interval Between Onset and Death<br><b>unknown years</b> |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>-----</b>  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>-----</b>   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>-----</b>  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>-----</b>   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>-----</b>  |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Max C. Frank</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>201825</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/2/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MAX C. FRANK 2510 Antebay Hwy - Glen Burnie MD</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>  |  |  |  |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Wiederholungen

90 08645

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>THOMAS D GOODHUES</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>04</b> DAY <b>10</b> YEAR <b>1990</b>  |  | 3. TIME OF DEATH<br><b>P. 10:13</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-28-7188</b>  |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <b>2</b> <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>56</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month/Day/Year)<br><b>12/30/33</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>HOMEWOOD HOSPITAL CENTER-SOUTH</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9c. COUNTY OF DEATH<br><b>Md.</b>   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>BALTIMORE</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>PARKVILLE</b>   |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>8710 EDGEFIELD RD.</b>  |  |   |  | 10f. ZIP CODE<br><b>21234</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>1</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Self-Employed Owner</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Bar</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Barond Goodhues</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Althea Bankerd</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. Michael Goodhues</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2320 Darby Ct. Belair, Md. 21014</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>DULANEY VALLEY 4/5/90</b>  |  | 20c. LOCATION — City or Town, State<br><b>TIMONIUM MARYLAND</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>DENNIS CAPITANO</b><br><i>Dennis A. Capitano</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>BALTIMORE MD. 21214</b><br><b>LEONARD J. RUCK INC. 5305 HARFORD RD.</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PROBABLE ACUTE MYOCARDIAL INFARCTION</b><br>Approximate Interval Between Onset and Death <b>TO DO</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Lymphoma</b>  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |   |  | 29c. LICENSE NUMBER<br><b>D6A34</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/11/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>APRIL J. HOMEWOOD CENTER SOUTH, BALTIMORE, MD 21218</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PEARL ELIZABETH HARRIS</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 1 90</b>   |  | 3. TIME OF DEATH<br><b>11 55A M</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>212-50-4038</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>8 - 22 - 05</b>                         |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MD.</b>  |  |  |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9b. COUNTY OF DEATH<br><b>Balt. City</b>   |   |
| 9c. FACILITY NAME (If not institution, give street and number)<br><b>Sinai Hospital of Balt.</b>  |  |  |  | 10a. STATE<br><b>Md.</b>  |  | 10b. COUNTY  |   |
| 10c. CITY, TOWN OR LOCATION<br><b>Balto.</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |   |
| 10e. STREET AND NUMBER<br><b>4105 Fords Lane</b>  |  |  |  | 10f. ZIP CODE<br><b>21215</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>           |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Walter Prout</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Stella</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Jean Harris</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16 B. Deer Run Ct., Balto., Md. 21227</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Arbutus Mem. Pk.</b>  |  | 20c. LOCATION — City or Town, State<br><b>Arbutus, Md.</b>  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Portia Chron</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>March F/H West<br/>4300 Wabash Ave.</b>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>LUNG CA (Metastatic)</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
|   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 25. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 6 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>a <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
|   |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Mark Esposito</b> PGY-1   |  |  |  | 29c. LICENSE NUMBER<br><b>9310</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/1/90</b>                                 |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARK ESPOSITO</b>   |  |  |  |   |  |  |   |
| 31. DATE OF DEATH (Month, Day, Year)<br><b>4 APR 4 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Rendell</b>  |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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24-27-28



90 08647

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Jimmy L. Hill</i>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>3 30 1990</i>  |  | 3. TIME OF DEATH<br><i>12:40 pm</i>   |   |
| 4. SOCIAL SECURITY NUMBER<br><i>238-40-0657</i>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><i>56</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>3/11/34</i>   |   |
| 8. RESIDENCE NAME (If not institution, give street and number)<br><i>Homewood Hosp.</i>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Balto.</i>  |  | 9c. COUNTY OF DEATH<br><i>N.C.</i>  |   |
| 10a. STATE<br><i>Md.</i>  |  |   |  | 10b. COUNTY<br><i>Baltimore</i>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><i>2310 Whittier Ave.</i>   |  |   |  | 10f. ZIP CODE<br><i>21217</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>Black</i>                      |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Construction</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>James Hill</i>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Eunice Moore</i>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Beatrice Hill</i>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>396 Waring Rd. Rochester, N.Y. 14609</i>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Western Star Cem.</i>  |  | 20c. LOCATION — City or Town, State<br><i>Catonsville, Md.</i>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Dorcia Elron</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>March F/H West<br/>4300 Wabash Ave.</i>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |   |  |   | Approximate Interval Between Onset and Death  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pulmonary embolism</i>   |  |   |  |   |  |   |   |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |   |  |   |  |   |   |
| b. <i>alcoholism</i> , <i>Pneumonia</i>   |  |   |  |   |  |   |   |
| c. <i>Chronic obstructive pulmonary disease</i>   |  |   |  |   |  |   |   |
| d. <i>Shock</i>   |  |   |  |   |  |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   |   |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |   |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>T. Hsu MD</i>   |  | 29c. LICENSE NUMBER<br><i>D05425</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>3/30/90</i>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>TAH-Hsiung Hsu MD 1900 E. Northern pky Baltimore MD 21239</i>   |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><i>APR 4 - 1990</i>  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROBERT L. Hunter</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>2</b> YEAR <b>90</b>   |  |  |  | 3. TIME OF DEATH<br><b>1:30</b> <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM    |  |
| 4. SOCIAL SECURITY NUMBER<br><b>240-44-7300</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>56</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>                           |  | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>                      |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>7-10-33</b>  |  |  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>N.C. Carolina</b>   |  |  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Bon Secours Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  |  |  | 9c. COUNTY OF DEATH   |  |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |  |  |   |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>B. Off.</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |
| 10e. STREET AND NUMBER<br><b>2223 Riggs Ave.</b>  |  |  |  | 10f. ZIP CODE<br><b>21216</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                               |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Towson High School</b><br><b>custodian</b>                       |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Paul Hunter, Sr.</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Maggie Taylor</b>  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Earline Smith</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2223 Riggs Ave., Balto., Md. 21216</b>   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Hunter Fam. Cem.</b>  |  |  |  | 20c. LOCATION — City or Town, State<br><b>Whitaker, N.C.</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Gola March</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>March F/H West</b><br><b>4300 Wabash Ave.</b>   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Carotid - pulmonary artery arrest</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br><b>acute pulmonary artery</b><br><b>as a result of</b> |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>(1) IDDM</b> <b>(2) Hypertension</b><br><b>(3) CRF</b>   |  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> NO |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO           |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                          |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Gregory D. W. D.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D-19528</b>  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/2/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Gula Davidson-Randall</b>  |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

012001 00

(Hoffenberg, Harriet)

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1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HARRIET HOFFENBERG</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 30 1990</b>   |  | 3. TIME OF DEATH<br>P M<br><b>7:20 P</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-44-0255</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>JUNE 11, 1910</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>  |  |
| 9c. COUNTY OF DEATH   |  |  |  | 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>BALTIMORE</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>3653 GLENGYLE AVE., APT. B2</b>   |  |
| 10f. ZIP CODE<br><b>21215</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>usa</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (13 or 5+) <b>5+</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>AT HOME</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>HARRY HOFFBERGER</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MOLLIE KRIEGER</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ALBERT HOFFENBERG</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3653 GLENGYLE AVE., APT. B2 BALTO., MD 21215</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CHIZUK AMUNO CONG.</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD., BALTO., MD 21215</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial Infarct</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF): <b>Peripheral Vascular disease</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. Approximate Interval Between Onset and Death<br><b>minutes</b><br><b>years</b> |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>congestive heart failure</b>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> <b>MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>P9470</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/30/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Paul Hope MD Johns Hopkins Hospital Baltimore, MD</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(Hoffenberg, Harriet)

2000-00

90 08650

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Charles W. Hunt</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>2</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>2:35 a.m.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216 34 8592</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>51 XXX</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year) <b>3-12-39</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Harbor Hospital Center</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore City</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Anne Arundel</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Pasadena</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>756 205th St.</b>  |  |
| 10f. ZIP CODE<br><b>21122</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1959 - 1963</b>   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |   |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |  |   |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Plumber</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Plumbing Company</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William S. Hunt</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Helen R. Grahe</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Evelyn M. Hunt</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>756 205th St., Pasadena, MD 21122</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>  |  |   |  |
| 20c. LOCATION — City or Town, State<br><b>Catonsville, MD</b>  |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Stephen J. Schumann</b>   |  |   |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>McCully Funeral Home of Pasadena<br/>3204 Mountain Rd., Pasadena, MD 21122</b>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>a. hepatic encephalopathy</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>b. renal failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>d.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate Interval Between Onset and Death |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I.  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |   |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br><b>M</b>   |  |   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>J.H. Jaster</b>   |  |   |  |
| 29c. LICENSE NUMBER  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-2-90</b>  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J.H. Jaster 3001 S. Hanover Baltimore, Md. 21230</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)  |  |  |  | 32. REGISTRAR'S SIGNATURE   |  |   |  |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION




1954-55

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  | 90 08651  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>Michael Inglese</b>  |  |  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 3 90</b>                        |  | 3. TIME OF DEATH<br><b>6 30 A M</b>   |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>124-01-9347</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>89</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2/8/01</b>                       |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Italy</b>  |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Dulaney Towson Nursing Home</b>  |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>                       |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |   |  |   |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Lutherville</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>7 Oak Ridge Court</b>  |  |  |  |  |  | 10f. ZIP CODE<br><b>21093</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b> |  |   |  |   |  |   |  |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>unknown</b><br>College (1-4 or 5+) <b>unknown</b>   |  |  |  | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>contractor</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>concrete</b>                          |  |   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Donato Inglese</b>  |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rose Roberto</b>   |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Neil Prisco</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7 Oakridge Court/Lutherville, MD 21093</b>   |  |  |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gardens of Faith Cemetery</b>                                   |  |  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>                |  |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Sterling Ashton Funeral Home, PA<br/>736 Edmondson Ave/Balto, MD 21228</b>  |  |  |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Emphysema</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |  |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>years</b>  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br><br><br>  |  |  |  |  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
|   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  |  |  | 29c. LICENSE NUMBER<br><b>D20673</b>                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/3/90</b>  |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>George Lowe 3703 Belair Rd Baltimore MD 21213</b>   |  |  |  |  |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |   |  |   |  |   |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Emilia Helena Kulacki</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 1, 1990</b>   |  | 3. TIME OF DEATH<br><b>3 PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-03-9678</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>93</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Jan 1, 1897</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Poland</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Manor Care-Ruxton</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Baltimore</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Lutherville</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>108 Othoridge Road</b>  |  |
| 10f. ZIP CODE<br><b>21093</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Homemaker</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Sigmund Michaels</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Leopoldine Clumb</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Emilia V. Voellger</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>108 Othoridge Road Lutherville, Md 21093</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Most Holy Redeemer Cemetery</b>   |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Bryan W. Clary</b>   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Lemmon-Mitchell-Wiedefeld Inc.<br/>10 W. Padonia Road Timonium, Md 21093</b>   |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Stroke</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br><b>CORONARY ARTERY DISEASE</b> |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>APR 1 1990</b>  |  |  |  |
| 28b. TIME OF INJURY<br><b>M</b>   |  |  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>A.H. Ghiladi, MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D-12849</b>  |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>4-1-90</b>  |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>A.H. GHILADI, MD. 7600 OSLER Dr. Towson MD 21204</b>   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rodella</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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90-08653

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MAZIE J. KANE</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>30</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br>M  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>216 10 22423</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year) <b>12-15-10</b>   |   |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>5858 STEVENS FOREST RD</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>COLUMBIA, MD</b>   |  | 9c. COUNTY OF DEATH  |   |
| 10a. STATE<br><b>MD</b>  |  |  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>COLUMBIA</b>   |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>5858 STEVENS FOREST RD</b>  |  | 10f. ZIP CODE<br><b>21045</b>  |   |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S. A</b>   |  |  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |   |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>SECONDARY</b> College (14 or 5+) <b>HOUSEWIFE</b>   |  |  |  | 16. KIND OF BUSINESS/INDUSTRY  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>CLARENCE DUTTON</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CATHERINE</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JAMES KANE JR.</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5858 STEVENS FOREST RD 21045</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ARBUTUS MEM. PK</b>   |  | 20c. LOCATION — City or Town, State<br><b>ARBUTUS MD</b>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Joseph B. Locks, Jr.</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Locks Funeral Home 13047N. Central St</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Multiple Myeloma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Chronic Renal Failure</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Diabetes Mellitus</b><br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 27. DATE OF INJURY (Month, Day, Year)  |  | 28. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |   |
| 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  | 29. DESCRIBE HOW INJURY OCCURRED   |  | 29d. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Paul Turner</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>021262</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/30/90</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>PAUL TURNER 900 CAZON AVE BALTIMORE MD 21229</b>   |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Gina Davidson-Randall</b>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FRED ISADORE KUHN</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 1, 1990</b>  |  | 3. TIME OF DEATH<br><b>11:40 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-05-0150</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Sept. 17, 1904</b>                      |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Switzerland</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Greater Baltimore Medical Center</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>                                 |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Towson</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |
| 10e. STREET AND NUMBER<br><b>7335 Yorktowne Drive</b>  |  |  |  | 10f. ZIP CODE<br><b>21204</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>              |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 Years</b><br>College (1-4 or 5+) <b>College</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Hairdresser</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Karl's</b>                                      |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>unknown</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Unknown</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lottie S. Kuin</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7335 Yorktowne Drive Towson, Md. 21204</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Greenmount Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Md.</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>James F. Burnside, Jr.</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Mitchell-Wiedefeld Home, Inc.<br/>6500 York Rd. Baltimore, Md. 21212</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrest</b>  |  |  |  |   |  |  |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |  |  |
| a. <b>Longstanding cardiac arrhythmia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>4 yrs</b>  |  |  |  |   |  |  |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> POA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Parking Lot of Hospital</b> |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Cardiac Arrest</b>   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Stephen Laiken, M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D 22517</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/2/90</b>                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Stephen Laiken, M.D. 6301 N. Charles St. Baltimore, Md. 21212</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Juli Davidson-Rodwell</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with care after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Herbert Kellum   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>4-2-90  |  | 3. TIME OF DEATH<br>1:30PM M   |  |
| 4. SOCIAL SECURITY NUMBER<br>202-12-6284   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>65 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>2/24/1925                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>1730 Mc Kean Avenue  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |  | 9c. COUNTY OF DEATH  |  |
| 10a. STREET AND NUMBER<br>1730 McKean Ave  |  |   |  | 10b. ZIP CODE<br>21217  |  | 10c. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>BLACK                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Retired Army                       |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Gertrude Kellum  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Louise Paul  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>616 Baker St Baltimore, Maryland 21207   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>GARRISON FOREST   |  | 20c. LOCATION — City or Town, State<br>Cwings Mill, Md  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Wm Brown  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>William C Brown Community F.H. 1206 W. North Ave  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic cardiovascular disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |   |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Diabetes Mellitus  |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>INSPECTION                                |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>XXXX YES 2 <input type="checkbox"/> NO   |  |   |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>XXX Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>XXXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Royce M. Kellum   |
| 29c. LICENSE NUMBER<br>OCME  |  |   |  |   |  |  | 29d. DATE SIGNED (Month, Day, Year)<br>4-3-90  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARGARITA A. KORELL, MD 111 Penn Street, Baltimore, MD 21201  |  |   |  |   |  |  | vc   |
| 31. DATE FILED (Month, Day, Year)<br>APR 4 - 1990  |  |   |  |   |  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1398

ITEMS:23,27 per ME G-663

5-9-90 cm

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BABY LINNEA J. Lewis</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-2-90</b>   |  | 3. TIME OF DEATH<br><b>6:55AM</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>NA</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>YRS. MONTHS DAYS<br><b>3 26</b>   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>12/7/89</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Johns Hopkins Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 9c. COUNTY OF DEATH<br><b>MD</b>  |  |
| 10a. STATE<br><b>MD.</b>   |  |  |  | 10b. COUNTY<br><b>BALTIMORE CITY</b>  |  | 10c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 10d. STREET AND NUMBER<br><b>927 NORTH BRADFORD STREET</b>   |  |  |  | 10f. ZIP CODE<br><b>21205</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>INFANT</b><br>College (1-4 or 5+) <b>CHILDREN</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>CHILDREN</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JUNIOUS LEWIS</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>SHARONDA MILES</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JUNIOUS LEWIS</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>927 Bradford St./Baltimore, MD. 21205</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>BALTIMORE CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Vanessa Davis</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>  |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ACUTE AND CHRONIC BRONCHITIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO           |  |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Vanessa Davis</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>OCME</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-2-90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br><b>MARIO F. GOLLE, JR., MD</b>   |  |  |  | 30. ADDRESS<br><b>111 Penn Street, Baltimore, MD 21201</b> vc   |  |   |  |
| 31. DATE FILLED (Month, Day, Year)<br><b>APR 4 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John H. ...</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Andrew Lewis Jr.   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>4 2 90  |  | 3. TIME OF DEATH<br>5:00 PM   |  |
| 4. SOCIAL SECURITY NUMBER<br>225-28-7170   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>69 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>June 10, 1920  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Virginia   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>9039 Sligo Creek Parkway Apt #202<br>None-Home   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Silver Spring  |  | 9c. COUNTY OF DEATH<br>Montgomery   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Montgomery  |  | 10c. CITY, TOWN OR LOCATION<br>Silver Spring  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>9039 Sligo Creek Parkway Apt #202  |  | 10f. ZIP CODE<br>20901   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black                                    |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 3rd<br>College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Laborer  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Construction  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Andrew Lewis Sr.  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Virginia Shackford   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Eleanor Lewis-Wife   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1937 N. Emerson St. Arlington, Va. 22207   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Fairview Cemetery  |  | 20c. LOCATION — City or Town, State<br>Culpepper, Virginia  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Robert B. Baker Jr.   |  | 22. NAME AND ADDRESS OF FACILITY<br>2605 S. Shipp, Arlington Road<br>Arlington, Virginia 22206   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cancer of the lung<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Atherosclerotic cerebrovascular disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. With stroke and left hemiplegia<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate interval between Onset and Death<br>1 yr.<br>years |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Alan Weinstein MD   |  |  |  | 29c. LICENSE NUMBER<br>0974840  |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/2/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr Alan R. Weinstein 10313 Georgia Ave Silver Spring MD   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 4 - 1990  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15200 02

90 08658

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CLARENCE M. LOCKHART SR.</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>2</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-24-1750</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>58</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>5-25-31</b>                        |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>2318 RIGGS AVENUE</b>   |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 8c. COUNTY OF DEATH<br><b>Md.</b>  |  |
| 10a. STATE<br><b>Md.</b>   |  |  |  | 10b. COUNTY<br><b>Balto.</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Balto.</b>                                 |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>2318 Riggs Avenue Apt. 3-A</b>   |  |  |  |
| 10f. ZIP CODE<br><b>21216</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>      |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Sinclair Lockhart</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sara</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Delores G. Lockhart</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2318 Riggs Avenue, Balto., Md. 21216</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Arbutus Mem. Pk.</b>  |  | 20c. LOCATION — City or Town, State<br><b>Arbutus, Md.</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Portia Chron</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM.C. MARCH F.H. 4300 WABASH AVENUE</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>throat cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  | Approximate interval between Onset and Death<br><b>4 weeks</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>D. Ames MD</b>   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/3/90</b>                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>D. Guesy MD 1205 Greene St Balt. MD 21201</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)  |  |  |  | 32. REGISTRAR'S SIGNATURE   |  |  |  |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



90 08659

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Melvin <u>JOSEPH</u> Loggins   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>April 3, 1990   |  | 3. TIME OF DEATH<br>10:15 M   |   |
| 4. SOCIAL SECURITY NUMBER<br>215 12 8969   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>85 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>12-15-04  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Maryland General Hospital   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |   |
| 9c. COUNTY OF DEATH<br>USA   |  |  |  |   |  |   |   |
| 10a. STATE<br>MARYLAND   |  | 10b. COUNTY<br>BALTO CITY  |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>1812 PARK AVE  |  |  |  | 10f. ZIP CODE<br>21217  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WW II   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: NEGRO                                    |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>RETIRED   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>BRADLEY LOGGINS   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>EMMA OWINGS  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>ERNEST LOGGINS   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1728 N. CAREY ST BALTO MD 21217  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>GARRISON FOREST V.A. BALTO CO. MD  |  | 20c. LOCATION — City or Town, State   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Joseph L. Russ  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>JOSEPH L. RUSS<br>2222 W. NORTH AVE 21216   |  |   |   |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. Fulminant Lung Metastasis<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>29b. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29c. SIGNATURE AND TITLE OF CERTIFIER<br>Jamal A. Halim  |  |  |  | 29c. LICENSE NUMBER<br>N/A  |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/3/90   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Jamal A. Halim, M.D. c/o Maryland General Hospital  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>APR 4 - 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |   |   |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 6 may be retained by the hospital or attending physician.

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TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, the conclusions drawn from the data, and the implications of the results.

4. The fourth part of the report is a discussion of the limitations of the study and suggestions for future research. It also includes a summary of the main findings and a final conclusion.

5. The fifth part of the report is a list of references and a list of figures. It also includes a list of tables and a list of appendices.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>(HILDEGARDE) HILDA B. LEMASTER   |  |  |  | 2. DATE OF DEATH 3-30-90<br>MONTH DAY YEAR  |  | 3. TIME OF DEATH 8:10 A M  |   |
| 4. SOCIAL SECURITY NUMBER<br>220-18-2304   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>84 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>AUG. 18, 1905                                 |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>WASHINGTON COUNTY HOSPITAL   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>HAGERSTOWN   |  | 9c. COUNTY OF DEATH<br>WASHINGTON  |   |
| 10a. STATE<br>MD   |  |  |  | 10b. COUNTY<br>WASHINGTON   |  | 10c. CITY, TOWN OR LOCATION<br>HAGERSTOWN  |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |   |
| 10e. STREET AND NUMBER<br>209 E. IRVIN AVENUE  |  |  |  | 10f. ZIP CODE<br>21740  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |   |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (14 or 5+) 5+  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>TEACHER   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>EDUCATION   |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>JAMES S. LEMASTER   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>MINNIE B. ARMSTRONG  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>MRS. PAULINE M. PALMER   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>RT. 2, BOX 114, MARTINSBURG, WV 25401  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>ROSEDALE CEMETERY  |  | 20c. LOCATION — City or Town, State<br>MARTINSBURG, WV 25401  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Charles M. Brown  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>BROWN FUNERAL HOME, 327 W. KING ST.<br>POBOX 821, MARTINSBURG, WV 25401   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated event resulting in death) LAST<br>a. Cardiac Arrest / Pulmonary Arrest.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Atherosclerotic Vascular Disease and<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. Congestive Heart Failure, Acute Myocardial<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. Mitral Insufficiency.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Carcinoma of breast<br>Hypoxic encephalopathy secondary to<br>cardiopulmonary resuscitation. |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br>36 hrs. |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Mary E. Money MD  |  |  |  | 29c. LICENSE NUMBER<br>023815   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3/30/90                                       |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Mary E. Money, MD 1708 Oak Hill Ave, Hagerstown, MD 21740   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>APR 4 - 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

02200 00

90 08661

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |  |   |
|--|--|---|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>John Joseph Morrissey</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 1 1990</b>  |  | 3. TIME OF DEATH<br><b>M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>212-05-3409</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>June 23 1906</b>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Ireland</b>   |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>2114 Sweetbriar Lane</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Timonium</b>   |   |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |   |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Baltimore</b>  |   |
| 10c. CITY, TOWN OR LOCATION<br><b>Timonium</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>2114 Sweetbriar Lane</b>  |   |
| 10f. ZIP CODE<br><b>21093</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |   |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Supervisor</b>                   |   |
| 15a. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16. KIND OF BUSINESS/INDUSTRY<br><b>B G &amp; E</b>   |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>Alexander Morrissey</b>  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Hannah Howell</b>  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Catherine D. Morrissey</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2114 Sweetbriar Lane, Timonium, Md. 21093</b>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Memorial Gardens Timonium, Md. 21093</b>  |  | 20c. LOCATION — City or Town, State  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Paul T. Lochstampf</i> <b>Paul T. Lochstampf</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lemmon-Mitchell-Wiedefeld<br/>Timonium, Maryland 21093</b>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIO-PULMONARY INSUFFICIENCY</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><b>ASCVD</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><b>PULMONARY / PROSTATIC NEOPLASM</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> |  |   |  |  |  |  | Approximate Interval Between Onset and Death<br><b>Acute</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Robert W. Lisle</i>  |  |   |  | 29c. LICENSE NUMBER<br><b>D14318</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/2/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Robert W. Lisle, M.D. 57 W. Timonium Rd., Timonium, Md. 21093</b>  |  |   |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90-08662

|  |  |  |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOANN M. MORRONE</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 10 90</b>   |  |  |  | 3. TIME OF DEATH<br><b>6:30 PM</b>  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>062-32-2391</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>48</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Apr. 16, 1941</b>                |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>New York</b>   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Annapolis</b>  |  |  |  | 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>  |  |  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Anne Arundel</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Edgewater</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br><b>117 Cardamon Drive</b>  |  |  |  | 10f. ZIP CODE<br><b>21037</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                             |  |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b> |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5 +</b> College (1-4 or 5+) <b>5 +</b>   |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Retail Sales</b>  |  | 16. KIND OF BUSINESS/INDUSTRY<br><b>Clothing</b>   |  |  |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Frank Pagano</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Jennie St. George</b>  |  |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Gerald C. Morrone</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>117 Cardomon Drive, Edgewater, MD 21037</b>  |  |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Hillcrest Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Annapolis, MD</b>  |  |  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Donald J. Taylor</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Taylor Funeral Chapel 21401<br/>147 Gloucester St., Annapolis, MD</b>   |  |  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CANCER OF COLON</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>METASTASIS TO LIVER, ABDOMEN</b><br>c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b><br>d. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)                                     |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John Davidson-Randall</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 58118</b>                                      |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/12/90</b>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>S P WATKINS 51 FRANKLIN ST ANN MD 21411</b>  |  |  |  |  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 13 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |  |  |   |  |  |  |

1. The first part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are in a printed hand. The list is organized in two columns. The first column contains the names, and the second column contains the addresses. The names are: John Smith, James Brown, William Jones, Robert Taylor, and Thomas White. The addresses are: 123 Main Street, New York, NY 10001; 456 Elm Street, New York, NY 10002; 789 Oak Street, New York, NY 10003; 101 Pine Street, New York, NY 10004; and 202 Cedar Street, New York, NY 10005.

2. The second part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are in a printed hand. The list is organized in two columns. The first column contains the names, and the second column contains the addresses. The names are: John Smith, James Brown, William Jones, Robert Taylor, and Thomas White. The addresses are: 123 Main Street, New York, NY 10001; 456 Elm Street, New York, NY 10002; 789 Oak Street, New York, NY 10003; 101 Pine Street, New York, NY 10004; and 202 Cedar Street, New York, NY 10005.

3. The third part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are in a printed hand. The list is organized in two columns. The first column contains the names, and the second column contains the addresses. The names are: John Smith, James Brown, William Jones, Robert Taylor, and Thomas White. The addresses are: 123 Main Street, New York, NY 10001; 456 Elm Street, New York, NY 10002; 789 Oak Street, New York, NY 10003; 101 Pine Street, New York, NY 10004; and 202 Cedar Street, New York, NY 10005.

4. The fourth part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are in a printed hand. The list is organized in two columns. The first column contains the names, and the second column contains the addresses. The names are: John Smith, James Brown, William Jones, Robert Taylor, and Thomas White. The addresses are: 123 Main Street, New York, NY 10001; 456 Elm Street, New York, NY 10002; 789 Oak Street, New York, NY 10003; 101 Pine Street, New York, NY 10004; and 202 Cedar Street, New York, NY 10005.

5. The fifth part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are in a printed hand. The list is organized in two columns. The first column contains the names, and the second column contains the addresses. The names are: John Smith, James Brown, William Jones, Robert Taylor, and Thomas White. The addresses are: 123 Main Street, New York, NY 10001; 456 Elm Street, New York, NY 10002; 789 Oak Street, New York, NY 10003; 101 Pine Street, New York, NY 10004; and 202 Cedar Street, New York, NY 10005.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Horace Montgomery JR.</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>04</b> DAY <b>03</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>3:40 P</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-186668</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>65</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>8/28/24</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>North Carolina</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Bon Secours</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  |
| 9c. COUNTY OF DEATH   |  |  |  | 10a. STATE<br><b>Md</b>  |  | 10b. COUNTY   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>1224 Oakhurst Pl.</b>  |  |
| 10f. ZIP CODE<br><b>21216</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <b>?</b> |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Machine Operator Beverage Distr. Co.</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Dever Montgomery</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Flonnie Montgomery</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Barbara Madden</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1224 Oakhurst Place</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mount Zion Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, County</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Kevin C. Cullen</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>1712-14th North Ave</b>   |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Overwhelming Sepsis -</b><br>DUE TO (OR AS A CONSEQUENCE OF) <b>coagulopathy - Severe metabolic</b><br>DUE TO (OR AS A CONSEQUENCE OF) <b>acidosis - Intractable carcinoma</b><br>DUE TO (OR AS A CONSEQUENCE OF) <b>of lung -</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  |   |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Penny Chhim, M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D26954</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>04-03-90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Penny Chhim, M.D. Bon Secours Hospital</b>  |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>Alfred John MATHIEU</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3/30/90</b>   |  | 3. TIME OF DEATH<br>HOUR MIN.<br><b>5/50 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>173-14-4812</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2-3-16</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Franklin Square Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rossville</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Baltimore</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Middle River</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>9728 Conmar Rd.</b>   |  |
| 10f. ZIP CODE<br><b>21220</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |  | 15. DECEASED'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b><br>College (1-4 or 5+) <b>College</b>   |  |  |  |
| 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Postal Worker</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U. S. Government</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Alfred Mathieu</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Emma Ammerman</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Helen Mathieu</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9728 Conmar Rd. Balto., Md. 21220</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Memorial Park</b>  |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>Towson, Maryland</b>  |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Jaschun F H mfg</b>  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>9728 Conmar Rd</b>   |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Intracerebral Hemorrhage</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>Hypertension</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  |  |  | 28b. TIME OF INJURY<br>HOUR MIN.   |  |  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Marc Litt</b>  |  |  |  |
| 29c. LICENSE NUMBER<br><b>D 34128</b>   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>APR 4 - 1990</b>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Marc Litt M.D. 9000 Franklin Square Dr. Baltimore, Md. 21237</b>  |  |  |  | 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>   |  |  |  |
| 32. REGISTRAR'S SIGNATURE<br><b>J. Davidson</b>   |  |  |  | 33. REGISTRAR'S TITLE<br><b>Registrar</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Paul L. McIntyre</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 2, 1990</b>   |  | 3. TIME OF DEATH<br><b>2:55 p m</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>176 32 1344</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 6, 1912</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>207 Cornfield Rd.</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Pasadena</b>   |  | 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>  |  |
| RESIDENCE OF DECEDENT  |  |   |  |  |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Anne Arundel</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Pasadena</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>207 Cornfield Rd.</b>   |  |   |  | 10f. ZIP CODE<br><b>21122</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1933 - 1963</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College (1-4 or 5+)</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Master Sergeant</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>United States Army</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>(Unknown)</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>(Unknown)</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Rachel McIntyre</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>207 Cornfield Rd., Pasadena, MD 21122</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Glen Haven Memorial Park</b>   |  | 20c. LOCATION — City or Town, State<br><b>Glen Burnie, MD</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Stephen D. Robinson</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>McCully Funeral Home of Pasadena<br/>3204 Mountain Rd., Pasadena, MD 21122</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Carcinoma of the lung</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>diabetes mellitus</b> |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>1 month</b>                                      |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>R. M. McLaughlin M.D.</i>  |  |   |  | 29c. LICENSE NUMBER<br><b>DO 7679</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/3/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>R. M. McLaughlin, M.D. 3708 Mountain Rd. Pasadena, Md. 21122</i>   |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>CATHERINE N. MURTHA</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 27 1990</b>  |  | 3. TIME OF DEATH<br><b>1:20 A M</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>183-14-2990</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>92</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>09-15-1897</b>  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>PENNSYLVANIA</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>LEVINDALE HEBREW GERIATRIC CENTER &amp; HOSPITAL</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>   |   |
| 9c. COUNTY OF DEATH   |  |  |  | 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>BALTIMORE</b>  |   |
| 10c. CITY, TOWN OR LOCATION<br><b>REISTERSTOWN</b>  |  |  |  | 10d. INSIDE CITY LIMITS<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>215 BOND AVENUE</b>   |   |
| 10f. ZIP CODE<br><b>21136</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>GRADE SCHOOL</b><br>College (1-4 or 5+) <b>COLLEGE (1-4 or 5+)</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOME MAKER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>GEORGE SCHORPT</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>UNKNOWN MERKLEIN</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>LORETTA C. BARR</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6370 WOODBINE AVENUE PHILADELPHIA, PA 19151</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify):  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>NEW CATHEDRAL CEM. 3-31-1990</b>   |  | 20c. LOCATION — City or Town, State<br><b>PHILADELPHIA, PA</b>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charles W. Fisher</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>DUDA-RUCK FUNERAL HOME OF DUNDALK, INC.<br/>7922 WISE AVENUE DUNDALK, MD 21222</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br>a. <b>SEPTICEMIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>GANGRENE OF RLE &amp; MULTIPLE INFECTED DEBRID.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>_____</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>_____</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ASCUT, CHRONIC ATRIAL FIBRILLATION, CVA</b>  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify):   |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |  |   |
| 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Carolecia O. Kn. M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D17037</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/27/90</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ESTRELLA O. Kn. M.D. - LEVINDALE HEBREW GERIATRIC CENTER &amp; HOSPITAL</b>   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. Anderson</i>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 08667

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mary Elizabeth Laughlin Norris</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 29 1990</b>  |  | 3. TIME OF DEATH<br>M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-32-3760</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>90</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept 4 1899</b>                            |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Meridian Nursing Home</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>  |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  |   |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Timonium</b>                                       |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br><b>2409 Chetwood Circle</b>   |  |  |  |
| 10f. ZIP CODE<br><b>21093</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>              |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Secretary</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Medical</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Henry Laughlin</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Margaret Tuttle</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Robert L. Norris</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2409 Chetwood Circle, Timonium, Md. 21093</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Woodlawn, Maryland</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Martin D. Lawson</i><br><b>Martin D. Lawson</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lemmon-Mitchell-Wiedefeld<br/>Timonium, Maryland 21093</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Cerebral</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><div style="display: flex; justify-content: space-between;"> <div>         a. DUE TO (OR AS A CONSEQUENCE OF):<br/> <b>Arteriosclerotic Cardiovascular Disease</b><br/>         b. DUE TO (OR AS A CONSEQUENCE OF):<br/> <b>Diabetes</b><br/>         c. DUE TO (OR AS A CONSEQUENCE OF):<br/> <br/>         d. DUE TO (OR AS A CONSEQUENCE OF):<br/> <br/> </div> <div>         Approximate interval Between Onset and Death<br/> <br/> <br/> <br/> <br/> <br/> <br/> </div> </div> |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Pneumonia</b>   |  |   |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Gracito V. Patricio</i><br><b>Gracito V. Patricio, M.D.</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>D08358</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br>▶   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Gracito V. Patricio, M.D. 8903 Harford Rd, Balto., Md. 21234</b>   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i><br><b>John Davidson</b>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DO NOT WRITE

DO NOT WRITE



**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**




DHMH-1A Rev 1/89



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ELIZABETH K. NAGLE</b>   |  |  |  |  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 3, 1990</b>  |  |  |  | 3. TIME OF DEATH<br><b>12:50 a.m.</b>   |  |  |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-14-1581</b>   |  |  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS. |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept 3, 1920</b>                           |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>MARYLAND GENERAL HOSPITAL</b>  |  |  |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  |  |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE CITY</b>  |  |  |  |   |  |  |  |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>-----</b>  |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore City,</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>1420 Holbrook Street</b>   |  |  |  |  |  |  |  | 10f. ZIP CODE<br><b>21202</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                |  |  |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b><br>College (1-4 or 5+) <b>College</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Waitress</b>                    |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Resturant</b>  |  |  |  |   |  |  |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joseph B. Nagle</b>   |  |  |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elizabeth K. Guilda</b>   |  |  |  |   |  |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Evelyn Nagle</b>   |  |  |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2502 Halcyon Avenue Baltimore, MD. 21214</b>  |  |  |  |   |  |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Greenmount Cemetery</b>   |  |  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD.</b>  |  |  |  |   |  |  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  |  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Dippel Funeral Home, Inc.<br/>7110 Belair Road Baltimore, MD. 21206</b>  |  |  |  |   |  |  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequitely list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <u>METASTATIC ESOPHAGEAL CARCINOMA</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. <u>SEPTICEMIA</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. _____ |  |  |  |  |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>_____   |  |  |  |  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | HOSPITAL:<br>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA             |  |  |  | OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |   |  |  |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURED  |  |  |  |   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br> M.D.   |  |  |  |  |  |  |  | 29c. LICENSE NUMBER<br><b>N/A</b>   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/3/90</b>  |  |  |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ERNEST UZICANIN, M.D. c/o MARYLAND GENERAL HOSPITAL</b>   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>                                 |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |

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100 13369

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 08670

|   |  |  |  |   |  |  |                                       |   |  |  |  |   |  |
|---|--|--|--|---|--|--|---------------------------------------|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>CARL J. OCONNELL  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>APRIL 1, 1990   |  | 3. TIME OF DEATH<br>9:35P M  |                                       |   |  |  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>219-44-8308  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>43 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>2-21-1947                                  |                                       | 8. BIRTHPLACE (State or Foreign Country)<br>N.Y.  |  |  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>THE JOHNS HOPKINS HOSPITAL  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |  |  | 9c. COUNTY OF DEATH<br>BALTIMORE CITY |   |  |  |  |   |  |
| RESIDENCE OF DECEDENT   |  |  |  | 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Baltimore   |                                       | 10c. CITY, TOWN OR LOCATION<br>Perry Hall   |  |  |  |   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br>9121 Kilbride Rd.   |  | 10f. ZIP CODE<br>21236   |                                       | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR OATES<br>Vietnam |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                  |                                       |   |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12 Yrs.  |  | 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Administrator Self Employed                    |  | 17. KIND OF BUSINESS/INDUSTRY<br>Insurance  |  |  |                                       |   |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John F. O'Connell  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Beatrice Valachovic  |  |  |                                       |   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Sandra L. O'Connell   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9121 Kilbride Rd., Perry Hall, Md. 21236   |  |  |                                       |   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Moreland Cemetery 4-5-90   |  | 20c. LOCATION — City or Town, State<br>Balto., Md.  |  |  |                                       |   |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Roy H. Cather<br>Roy H. Cather   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Leonard J. Ruck, Inc., 5305 Harford Rd., Balto., Md. 21214  |  |  |                                       |   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. Hepatic Failure<br>b. Alcoholic Cirrhosis<br>c. Alcoholism<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  |                                       | Approximate Interval Between Onset and Death<br>1 week<br>1 year<br>7 yrs.                                |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  |                                       | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | HOSPITAL:<br>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA                           |  | 26. PLACE OF DEATH (Check only one)<br>OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                            |  |  |                                       |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                       | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |                                       |   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |                                       | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>H. J. H. H.  |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/1/90 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>A. D. Adams 600 N. Wake St Baltimore MD 21205  |  |  |  |   |  |  |                                       | 31. DATE FILED (Month, Day, Year)<br>4 APR 1990   |  | 32. REGISTRAR'S SIGNATURE<br>John H. H. H.   |  |   |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>OSCAR J. PARKER Jr.</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>03</b> / DAY <b>30</b> / YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>12:07 PM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>165-20-6529</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>5-4-1926</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Scranton, Pa.</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Harbor Hos. Ctr.</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  |
| 9c. COUNTY OF DEATH  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY<br><b>Harford Co.</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Fallston</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>1005 Dellwood Dr.</b>   |  |  |  | 10f. ZIP CODE<br><b>21047</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II 1944-46</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                      |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>12</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Underwriting Mgr.</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Md. Casualty Co.</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Oscar J. Parker Sr.</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Grace Howell</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Vivian C. Parker</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1005 Dellwood Dr. Fallston, Md. 21047</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Belair Memorial Gardens</b>   |  | 20c. LOCATION — City or Town, State<br><b>Bel Air, Md.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>E.F. Lassahn</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>E.F. Lassahn Funeral home<br/>11750 Belair Rd. Kigsville, Md. 21087</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>METASTATIC PROSTATIC CANCER</b>   |  |  |  |   |  |   |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| b. <b>GASTRIC BLEEDING.</b>  |  |  |  |   |  |   |  |
| c. <b>SEPSIS</b>   |  |  |  |   |  |   |  |
| d.   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>G. Nimmagadda House Staff Phy.</b>   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>03/30/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>G. NIMMAGADDA HARBOR HOSPITAL CENTER BALTIMORE</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

17250 00



ITEM:20b per FH G-662

4-11-90 cm

1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 08672

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Proctor James</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 30, 1990</b>   |  | 3. TIME OF DEATH<br><b>11:25 A.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>578-58-3532</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>45</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Feb 11, 1945</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Wash., D.C.</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Joseph Richey Hospice</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore, 21201, MD</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Prince Georges</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Hyattsville</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>7721 Penn Brook Place</b>   |  |
| 10f. ZIP CODE<br><b>20742</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>   |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Supervisor</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Parking lot</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JAMES H. PROCTOR</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARCY C. WOODLAND</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARY C. GOLDRING (DAUGHTER)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6849 South Field Rd., Ft. Wash., Md. 20744</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>4/6/90</b>  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MARYLAND VETERANS CEMETERY</b>   |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>CHELTENHAM MD</b>  |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Alex S. Pope Jr.</b>  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>ALEXANDER S POPE FUNERAL HOME</b><br><b>2617 PA AVE SE WASHINGTON DC 20020</b>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lung Cancer</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Carcinomatous Meningitis</b><br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>   |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> NO  |  |  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Iredell W. Iglehart III MD</b>  |  |  |  |
| 29c. LICENSE NUMBER<br><b>D33400</b>   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/30/90</b>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Iredell W. Iglehart III MD 500 W. University Plany Balto MD 21210</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 1990</b>   |  |  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

25200 00



90 08673

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |                                |   |  |   |  |
|---|--|---|--|---|--------------------------------|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EGBERT LOVELAND ROTHERMUND</b>   |  |   |  |   |                                | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 30 1990</b>   |  | 3. TIME OF DEATH<br><b>4:15 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>291-09-4621</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>09 28 1917</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>OHIO</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>G.B.M.C.-6701 N. CHARLES STREET</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE, MD 21204</b>   |                                | 9c. COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b>  |  |   |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |                                |   |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>BALTIMORE COUNTY</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>TIMONIUM</b>  |                                | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |
| 10a. STREET AND NUMBER<br><b>2132 FOUNTAIN HILL DRIVE</b>   |  |   |  | 10f. ZIP CODE<br><b>21093</b>   |                                | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                          |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>4</b>   |  |   | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Salesman</b> |   |                                | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Chevron USA</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>KARL ROTHERMUND</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ANNA LOVELAND</b>   |                                |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Elizabeth S. Rothermund</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2132 Fountain Hill Dr. Timonium, Md 21093</b>   |                                |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Millersport Cemetery</b>   |  |   |                                | 20c. LOCATION — City or Town, State<br><b>Millersport, Ohio</b>                                     |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Bryan W. Clary</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lemmon-Mitchell-Wiedefeld Inc.<br/>10 W. Padonia Road Timonium, Md. 21093</b>  |                                |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>METASTATIC PROSTATE CANCER</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |                                |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ISCHEMIC HEART DISEASE</b>   |  |   |  |   |                                |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
|   |  |   |  |   |                                |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |                                |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |                                | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
|   |  | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |                                | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |                                |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>James J. [Signature]</b>  |  |   |  |   |                                | 29c. LICENSE NUMBER<br><b>D15561</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/30/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J B [Signature] 6301 N Charles St, Balto, Md 21206</b>  |  |   |  |   |                                |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia [Signature]</b>   |                                |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 08674

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |                        |   |  |   |  |   |  |   |                        |                                  |                    |                                  |    |  |  |  |
|--|------------------------|---|--|---|--|---|--|---|------------------------|----------------------------------|--------------------|----------------------------------|----|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FREDERICK JOSEPH REUWER</b>   |                        |   |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>1</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>6:30 A.</b>  |  |   |                        |                                  |                    |                                  |    |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-12-7100</b>  |                        | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <b>2</b> <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10/15/15</b>  |  |   |                        |                                  |                    |                                  |    |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Key Circle Conv. Center</b>   |                        |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH   |  |   |                        |                                  |                    |                                  |    |  |  |  |
| RESIDENCE OF DECEDENT  |                        |   |  |   |  |   |  |   |                        |                                  |                    |                                  |    |  |  |  |
| 10a. STATE<br><b>Maryland</b>  |                        | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |  |   |                        |                                  |                    |                                  |    |  |  |  |
| 10e. STREET AND NUMBER<br><b>2820 Waterview Ave.</b>   |                        |   |  | 10f. ZIP CODE<br><b>21230</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |                        |                                  |                    |                                  |    |  |  |  |
| 11. MARITAL STATUS<br><b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced  |                        | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>  |  |   |                        |                                  |                    |                                  |    |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>9th Grade</b>  |                        | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Sanitation Dept.</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Baltimore City</b>   |  |   |  |   |                        |                                  |                    |                                  |    |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Godrey Reuwer</b>  |                        |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Frances Coop</b>  |  |   |  |   |                        |                                  |                    |                                  |    |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Frances Boyd</b>  |                        |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2820 Waterview Ave. Baltimore, Md. 21230</b>  |  |   |  |   |                        |                                  |                    |                                  |    |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input type="checkbox"/> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)   |                        | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>   |  |   |  |   |                        |                                  |                    |                                  |    |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James L. Goff</i>  |                        |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hubbard Funeral Home, Inc. 21229<br/>4107 Wilkens Ave. Baltimore, Maryland</b>   |  |   |  |   |                        |                                  |                    |                                  |    |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |                        |   |  |   |  |   |  |   |                        |                                  |                    |                                  |    |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIO PULMONARY ARREST</b>   |                        |   |  |   |  |   |  |   |                        |                                  |                    |                                  |    |  |  |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |                        |   |  |   |  |   |  |   |                        |                                  |                    |                                  |    |  |  |  |
| <table border="0"> <tr> <td rowspan="4" style="vertical-align: middle; font-size: 4em;">{</td> <td>b. <b>MALNUTRITION</b></td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> </tr> <tr> <td>c. <b>DEMENTIA</b></td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> </tr> <tr> <td>d.</td> <td></td> </tr> <tr> <td></td> <td></td> </tr> </table>   |                        |   |  |   |  |   |  | { | b. <b>MALNUTRITION</b> | DUE TO (OR AS A CONSEQUENCE OF): | c. <b>DEMENTIA</b> | DUE TO (OR AS A CONSEQUENCE OF): | d. |  |  |  |
| {  | b. <b>MALNUTRITION</b> | DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |   |                        |                                  |                    |                                  |    |  |  |  |
|  | c. <b>DEMENTIA</b>     | DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |   |                        |                                  |                    |                                  |    |  |  |  |
|  | d.                     |   |  |   |  |   |  |   |                        |                                  |                    |                                  |    |  |  |  |
|  |                        |   |  |   |  |   |  |   |                        |                                  |                    |                                  |    |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>RECURRENT HEMATURIA</b>   |                        |   |  |   |  |   |  |   |                        |                                  |                    |                                  |    |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |                        | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |                        |                                  |                    |                                  |    |  |  |  |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide  |                        | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO     |  |   |                        |                                  |                    |                                  |    |  |  |  |
|  |                        | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                      |  |   |                        |                                  |                    |                                  |    |  |  |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                        |   |  |   |  |   |  |   |                        |                                  |                    |                                  |    |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Samuel K. Tulka</i>  |                        |   |  | 29c. LICENSE NUMBER<br><b>D-27188</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-2-90</b>  |  |   |                        |                                  |                    |                                  |    |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Julka 2900 Dunran Road Baltimore, Md.</b>  |                        |   |  |   |  |   |  |   |                        |                                  |                    |                                  |    |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>   |                        | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>   |  |   |  |   |  |   |                        |                                  |                    |                                  |    |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SAMMYE F. ROTHHOLZ</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 29 1990</b>   |  | 3. TIME OF DEATH<br><b>1:55 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-48-6627</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>OCT 25 1905</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>LEVINITAVE HEBREW GERIATRIC CENTER &amp; HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE, MARYLAND</b>  |  | 9c. COUNTY OF DEATH<br><b>OKLAHOMA</b>   |  |
| 10a. STATE<br><b>MD</b>   |  |  |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>3603 LABYRINTH RD., APT. 1F</b>   |  | 10f. ZIP CODE<br><b>21215</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>1</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>AT HOME</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>SAMUEL HEILBRON</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CELIA HIRSCH</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MR. MICKEY ROTHHOLZ, JR.</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3415 CLARKS LA., APT. 1C BALTIMORE, MD 21215</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>OHED SHALOM</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SOL LEVINSON &amp; BROS, INC.<br/>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>LUNG CARCINOMA</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. |  |  |  |  |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO      |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)   |  |
| 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  | 29c. LICENSE NUMBER<br><b>D17037</b>   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>3/29/90</b>   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ESTRELLITA O. KIM M.D. - LEVINITAVE HEBREW GERIATRIC CENTER &amp; HOSPITAL, BALTIMORE</b>  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

672-00



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>BABY BOY <u>RYAN JOSEPH</u> RODOWSKI  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>APRIL 3, 1990   |  | 3. TIME OF DEATH<br>2:15A M  |  |
| 4. SOCIAL SECURITY NUMBER<br>-----  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (in yrs. last birthday)<br>YRS. MONTHS DAYS<br>/ 8   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>3-26-90  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>THE JOHNS HOPKINS HOSPITAL  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |  | 9c. COUNTY OF DEATH<br>BALTIMORE CITY  |  |
| 10a. STATE<br>MD  |  |   |  | 10b. COUNTY<br>BALTIMORE  |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br>JOHNS HOPKINS HOSPITAL  |  |  |  |
| 10f. ZIP CODE   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (14 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)                                       |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>ROBERT LEE RODOWSKI  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>MICHELE DENISE IPSARO  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>ROBERT L. RODOWSKI  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>306 3RD. ST., BALTO., MD. 21237  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>GARDENS OF FAITH  |  | 20c. LOCATION — City or Town, State<br>BALTO., MD   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Denise J. Polanski</u>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>CVACH/ROSEDALE FUNERAL HOME<br>1211 CHESACO AVE., BALTO., MD 21237  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Hypoplastic left heart</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  | Approximate Interval Between Onset and Death<br>8 days   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Prematurity</u><br><u>Respiratory Distress Syndrome</u>  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)<br>N/A   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>B. Orzech and</u>  |  |
| 29c. LICENSE NUMBER   |  |   |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/3/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Orzech   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 4 - 1990   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general description of the project.

2. The second part of the report is a detailed description of the project.

3. The third part of the report is a summary of the project.

90 08677

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Victor Hoover Sell</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 31 1990</b>   |  | 3. TIME OF DEATH<br><b>M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>191-07-8983</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Nov. 4 1902</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Greater Baltimore Medical Center</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Timonium</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>20 Gorsuch Road</b>  |  |   |  | 10f. ZIP CODE<br><b>21093</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 Years</b><br>College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Buyer</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Bendix Corp.</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Brook Sell</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Maggie (unknown by informant)</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. &amp; Mrs. Wilbert Edwards</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1031 Lakemont Rd., Catonsville, Md. 21128</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Memorial Gardens</b>  |  | 20c. LOCATION — City or Town, State<br><b>Timonium, Md. 21093</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Paul T. Lochstampf</i> <b>Paul T. Lochstampf</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lemmon-Mitchell-Wiedefeld<br/>Timonium, Maryland 21093</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Immediate Cause (Final disease or condition resulting in death) →</b><br><i>Myocardial Infarction</i><br><b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br><b>CDPD</b> |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>Immediate</b><br><b>unknown</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|   |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  |
|   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Barry Weckesser</i>   |  | 29c. LICENSE NUMBER<br><b>D12035</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/3/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Barry Weckesser, M.D., 660 Kenilworth Dr., Towson, Md. 21204</b>  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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173



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EUGENE H. SKINNER</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 1 90</b>   |  | 3. TIME OF DEATH<br><b>3:30 P M</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>219-42-6231</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11/25/11</b>                               |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Hm. 1502 Park Ave. 21217</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore, Md.</b>  |  | 9c. COUNTY OF DEATH<br><b>City</b>   |   |
| 10a. STATE<br><b>Md.,</b>   |  |  |  | 10b. COUNTY<br><b>- - -</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                      |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  |   |
| 10e. STREET AND NUMBER<br><b>Hm. 1502 Park Ave. Baltimore</b>   |  |  |  | 10f. ZIP CODE<br><b>21217</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>           |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) College (1-4 or 5+)<br><b>unknown</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>clerk</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>social security</b>  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James P. Skinner</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Hallie Smith</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Jonathan Skinner</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7710 Bagley Ave/Balto. MD 21234</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Greenmount Crematory</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Md.</b>  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Bradley-Ashton Funeral Home, Inc.<br/>2134 Willow Spring Rd. Dundalk, Md. 21222</b>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Prostate Cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. _____<br>b. _____<br>c. _____<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>e. _____<br>f. _____<br>g. _____<br>h. _____ |  |  |  |   |  |  | Approximate interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cerebrovascular disease</b>  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br> MD   |  |  |  | 29c. LICENSE NUMBER<br><b>D33897</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/2/90</b>                                 |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Robert Vissing, MD 4300 N. Charles St. 21218</b>  |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Augusta W. Schmitt</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>2</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>8:25 a.</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-30-4077</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>91</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>12 21 98</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Martin's Home for the Aged</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Catonsville</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| 10a. STATE<br><b>Md.</b>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |
| 10e. STREET AND NUMBER<br><b>5626 Woodmont Ave.</b>   |  |  |  | 10f. ZIP CODE<br><b>21239</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                            |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>82</b> College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Stenographer-Housekeeper</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Office- Rectory</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Paul Wille</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Wille</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Sr. Dorene</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>601 Maiden Choice Lane Balto., Md. 21228</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Sacred Heart of Jesus</b>   |  | 20c. LOCATION — City or Town, State<br><b>Dundalk, Maryland</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hubbard Funeral Home, Inc.<br/>4107 Wilkens Ave. Baltimore, Md. 21229</b>  |  |   |  |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Carcinoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Pelvic carcinoma</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Severe Arthritis, Parkinson's disease<br/>Depression</b>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO           |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
|   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br><b>021649</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-2-90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Sambandam Baskaran 3455 Wilkens Ave. Balto., Md. 21229</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <b>ARL HOSIE SMITH</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>03</b> DAY <b>31</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>5:50 P.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-34-3481</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>66</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>02 23 24</b>                                       |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>UNIVERSITY OF MARYLAND</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>708 N. Payson St</b>  |  |  |  | 10f. ZIP CODE<br><b>21217</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Disability</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Edward Smith</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sarah Washington</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Ernestine Smith</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>708 N. Payson St Balto. Md. 21217</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Maryland Nat Park</b>   |  | 20c. LOCATION — City or Town, State<br><b>AA Co. Md.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Joseph L. Russ</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Joseph L. Russ Funeral Home<br/>32224 North Ave. Balto. Md. 21216</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIOPULMONARY ARREST</b>  |  |  |  |   |  |   | <b>1 WEEK</b>  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| b. <b>MULTI-ORGAN SYSTEM FAILURE</b>   |  |  |  |   |  |   | <b>3 DAYS</b>  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| c. <b>SEPSIS</b>   |  |  |  |   |  |   | <b>5 DAYS</b>  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| d. <b>POSTOBSTRUCTIVE PNEUMONIA / SP GASTRIC ULCER W/ BLEED / PESSERAS - BACK AREA / LOOK-EN - IN STERILE POUCH</b>  |  |  |  |   |  |   | <b>13 DAYS</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Metastatic Lung Cancer</b>  |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Geoffrey Small MD</b>  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/31/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>UNIVERSITY OF MARYLAND MEDICAL SYSTEM 22 S. GREENE ST. BALT 21201</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Pendell</b>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

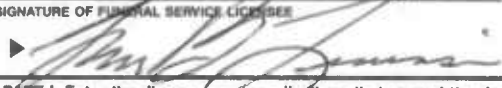
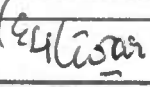
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1997-02

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SYLVIA STERN</b>   |  | 2. DATE OF DEATH<br>MONTH <b>7</b> DAY <b>6</b> YEAR <b>20</b>  |  | 3. TIME OF DEATH<br><b>4-08 A</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-09-2289</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.  |  |
| 7. DATE OF BIRTH (Month, Day, Year)<br><b>7-7-20</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>   |  | 9. FACILITY NAME (If not institution, give street and number)<br><b>LEVINDALE</b>   |  |
| 10. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  | 11. RESIDENCE OF DECEDENT<br>10a. STATE <b>MARYLAND</b> 10b. COUNTY <b>BALTIMORE</b>  |  | 12. CITY, TOWN OR LOCATION<br><b>OWINGS MILLS</b>   |  |
| 13. STREET AND NUMBER<br><b>4-D HIAWATHA CT.</b>  |  | 14. ZIP CODE<br><b>21117</b>  |  | 15. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 16. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 17. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |
| 19. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>BOOK KEEPER</b>   |  | 20. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>BOOK KEEPER</b>   |  | 21. KIND OF BUSINESS/INDUSTRY<br><b>EYEGLASSES</b>  |  |
| 22. FATHER'S NAME (First, Middle, Last)<br><b>ABRAHAM STERN</b>   |  | 23. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>BESSIE GREENBLATT</b>   |  |   |  |
| 24. INFORMANT'S NAME (Type/Print)<br><b>MR. MARTIN M. STERN</b>   |  | 25. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2 STONEHENGE CIR., APT. 7 BALTIMORE, MD 21208</b>  |  |   |  |
| 26. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 27. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>BETH HAMEDROSH HAGODOL</b>  |  | 28. LOCATION — City or Town, State<br><b>ROSEDALE, MD</b>   |  |
| 29. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  | 30. NAME AND ADDRESS OF FACILITY<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |   |  |
| 31. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MYELOPROLIFERATIVE DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. _____<br>b. _____<br>c. _____<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |
| 32. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____<br>_____  |  |   |  |   |  |
| 33. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 34. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 35. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 36. DATE OF INJURY (Month, Day, Year)   |  | 37. TIME OF INJURY<br><b>M</b>  |  |
| 38. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 39. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |
| 40. DESCRIBE HOW INJURY OCCURRED  |  | 41. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 42. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |
| 43. SIGNATURE AND TITLE OF CERTIFIER<br>   |  | 44. LICENSE NUMBER<br><b>125610</b>   |  | 45. DATE SIGNED (Month, Day, Year)<br><b>3.30.90</b>  |  |
| 46. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>SET HIWAR, 40 LEVINDALE 2434 W. BELVERDERE AVE, BALTIMORE, MD 21215</b>   |  |   |  |   |  |
| 47. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>  |  |   |  |   |  |

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THE JOURNAL

REG. NO.

DMMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Hildegard M. Seeboth</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>04</b> DAY <b>01</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>07:10 A<sup>M</sup></b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>578-46-1308</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>JAN. 2, 1903</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>MONTGOMERY GENERAL HOSPITAL<br/>18101 Prince Phillip Drive</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Olney, Maryland 20832</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>MONT</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>SANDY SPRING</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>17330 QUAKER LANE</b>   |  | 10f. ZIP CODE<br><b>20860</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Music teacher</b>            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Music</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>GUSTAV WOLTER</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>META WOLF</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CONRAD M. SEEBOTH</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6003 Joyce Drive Camp Springs, Md. 20748</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GATE OF HEAVEN CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>SILVER SPRING, MD.</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Maribel Barker</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MURIEL H. BARBER FUNERAL HOME<br/>21525 LAYTONSVILLE RD. LAYTONSVILLE, MD. 20882</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Small Cell carcinoma of the lungs</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. with metastasis to bone 5. (T<sub>1</sub>)</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>3-4 weeks</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive heart failure, hypertension, diabetes, peripheral vascular disease</b>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Ruben C. Cosca M.D.</i>  |  | 29c. LICENSE NUMBER<br><b>DO4421 (MD)</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/1/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>RUBEN C. COSCA M.D. 17529 RED CLOUD ROAD, DEERWOOD, MD 20851</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rendell</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


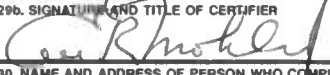
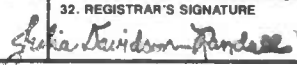




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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Marjorie K. Vick</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 1 90</b>   |  | 3. TIME OF DEATH<br><b>10:00 P. M.</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>212-05-3184A</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>7/24/14</b>  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>501 South Rolling Road</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |   |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>21228</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>501 South Rolling Road</b>  |  |  |  | 10f. ZIP CODE<br><b>21228</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                      |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>unknown</b><br>College (1-4 or 5+) <b>unknown</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>school teacher</b>       |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Baltimore County Schools</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Ferdinand Kuhns</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Genevieve McCosh</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Charlotte Tonini</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3627 Ashley Court/Palm Harbor, FLA 34689</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Michael's Cemetery</b>                                      |  | 20c. LOCATION — City or Town, State<br><b>Poplar Spring, MD</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Sterling Ashton Funeral Home, PA<br/>736 Edmondson Ave/Balto. MD 21228</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Multiple Myeloma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br><b>D07249</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/2/90</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ST AGNES 900 CATON AVE BALTO MD 21229</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br>                             |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>ELMIRA WEIPPERT  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>4 2 90   |  | 3. TIME OF DEATH<br>1.55 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>220-20-2233   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>61 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>11/21/28   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |  |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore   |  | 9c. COUNTY OF DEATH  |  |
| 9b. FACILITY NAME (If not institution, give street and number)<br>Bon Secours Hospital   |  |  |  |  |  |  |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br>2120 Eagle Street  |  |  |  | 10f. ZIP CODE<br>21223   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>11th Grade  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Howard Willey   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Grace Henninger   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Ronald Weipper, Sr.  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 487 Ridgely, Maryland 21660  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Loudon Park Cemetery   |  | 20c. LOCATION — City or Town, State<br>Baltimore, Maryland   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Rogers Peterson</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Hubbard Funeral Home, Inc.<br>4107 Wilkens Ave. Baltimore, Md. 21229   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiac arrest</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>hypertension</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>Metastatic Breast Cancer</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br>5 minutes |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28. DATE OF INJURY (Month, Day, Year)<br>28b. TIME OF INJURY<br>28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>28d. DESCRIBE NOW INJURY OCCURRED |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Dr. Weiner</i>   |  | 29c. LICENSE NUMBER<br>B34043  |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/3/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Weiner<br>4660 Wilkens Ave. Baltimore, Md. 21228  |  |  |  | 31. DATE FILED (Month, Day, Year)<br>APR 4 - 1990  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EARLY NMT Witherspoon</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>04 1 90</b>  |  | 3. TIME OF DEATH<br><b>4:57 AM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-22-1976</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>61</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>0615928</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>University Hosp.</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore Md</b>  |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><b>Md</b>   |  | 10b. COUNTY<br><b>BC</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore Maryland</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                        |  |
| 10e. STREET AND NUMBER<br><b>2136 Koko Lane</b>   |  |   |  | 10f. ZIP CODE<br><b>21216</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>Yes Md</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMY FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>KORSAK</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Retired</b>                                 |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Abramham Witherspoon SR.</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY Epps</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. Abramham Witherspoon</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2136 Koko Lane Balto. Md. 21216</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GARRISON Forest Hl. Cem. Balto. Co. Md</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTO. Co. Md</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Joseph L. Russ</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Joseph L. Russ Funeral Home<br/>2222 W. North Ave. Balto. Md 21216</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory failure</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br><b>Spiral cord injury</b> |  |   |  |   |  |  | Approximate interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Spiral cord injury</b>   |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>APPROVAL                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br><b>2-24-90</b>   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                            |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Subject fell at home</b>  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>home</b>   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>2136 CoCo Lane, Baltimore City,</b> |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Maryland<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Wade Gaasch, M.D.</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>037818</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/1/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>WADE GAASCH M.D.</b>  |  |   |  |   |  |  |  |
| 31. DATE OF DEATH (Month, Day, Year)<br><b>APR 4 - 1990</b>   |  |   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-10-50

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 08687

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Frank E. White</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 1 90</b>   |  | 3. TIME OF DEATH<br><b>1230 P M</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>21560</b>   |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>37</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>1-14-53</b>  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Univ of MD Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH  |   |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>2135 N. FULTON AVE</b>   |  |  |  | 10f. ZIP CODE<br><b>21217</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 11. MARITAL STATUS<br><b>3</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>NRERO</b>                               |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>DISABILITY</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>WESTLEY WHITE</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MAZOLA CHAPMAN</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MAZOLA WHITE</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1601 CLIFTON AVE BALTO MD 21219</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>WESTERN STAR CEM</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTO CO MD</b>   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Joseph L. Russ</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>2222 W NORTH AVE 21216<br/>Joseph L. Russ FH</b>   |  |  |   |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>End Stage Renal disease</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <b>AIDS</b><br>b.<br>c.<br>d.<br>Approximate Interval Between Onset and Death<br><b>~1yr</b><br><b>~1yr</b> |  |  |  |   |  |  |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO                                   |
|   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>7</b> <input type="checkbox"/> Homicide <b>4</b> <input type="checkbox"/>   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO       |   |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                             |   |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Wendy Dubin M.D.</b>  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/1/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Wendy Dubin M.D. Univ of MD Hospital 22 S Greene St</b>   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |  |   |





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ELISHA WRIGHT</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>2</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>1:15</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>465-03-0944</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>1/24/14</b>                     |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>LIBERTY MEDICAL CENTER</b>  |  |   |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9b. COUNTY OF DEATH<br><b>BALTIMORE CITY</b>                                 |  |
| 10a. STATE<br><b>MD</b>   |  |   |  | 10b. COUNTY<br><b>M/H</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore City</b>                         |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br><b>708 Reedbird Ave</b>   |  |  |  |
| 10f. ZIP CODE<br><b>21225</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>W.W.II</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br><b>Black</b>               |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/>  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Longshoreman</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Harold Wright</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lillie Smith</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary E. Wright</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>708 Reedbird Ave - Balt. MD, 21225</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>V.A. Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Crownsville, MD</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>W. Small</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Wright Community<br/>1712-14 W. North Ave</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrest</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>Respiratory Failure</b><br>c. <b>Pneumonia</b> |  |   |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Sher A Hashmi MD</b>   |
| 29c. LICENSE NUMBER<br><b>024648</b>  |  |   |  |   |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-2-90</b>   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>SHER HASHMI 2600 LIBERTY HEIGHTS AVE BALTIMORE 21215</b>  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 4 - 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Jake Davidson</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

502

071



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| #4, per F.H. 4/6/90 kam  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 90 08689  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Annie L. White   |  |  |  | 2. DATE OF DEATH<br>MONTH 3 DAY 30 YEAR 90  |  | 3. TIME OF DEATH<br>3:30 PM M  |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>NA 216-46-6431  |  | 5. SEX<br>1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>98 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>1-14-1892                                     |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>4630 Buck School House Rd.   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>White Marsh  |  | 9c. COUNTY OF DEATH<br>Baltimore   |  |   |  |   |  |
| 10a. STATE<br>Maryland   |  |  |  | 10b. COUNTY<br>Baltimore  |  | 10c. CITY, TOWN OR LOCATION<br>White Marsh   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO         |  |   |  |
| 10e. STREET AND NUMBER<br>4630 Buck School House Rd.   |  |  |  | 10f. ZIP CODE<br>21237  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6 years<br>College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Housewife                          |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Homemaking  |  |  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>George Wolf   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Unknown  |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Margaret F. Wolf  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4900 White Marsh Rd. Balto., Md. 21237   |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>St. Peter's Lutheran Ch. Cem.  |  | 20c. LOCATION — City or Town, State<br>Fullerton, Maryland  |  |  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Lassahn Funeral Home Inc.   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Lassahn Funeral Home<br>7401 Belair Rd. Balto., Md. 21236   |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Arteriosclerotic Cardiovascular Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  |  | Approximate interval Between Onset and Death<br>Unknown   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>None   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA                        |  | 26. PLACE OF DEATH (Check only one)<br>OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)             |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Stanley Felsenberg Deputy Medical Examiner  |  | 29c. LICENSE NUMBER<br>001086   |  | 29d. DATE SIGNED (Month, Day, Year)<br>Apr 2, 1990                                   |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Stanley Felsenberg 11 E. Chase St. (Cor. St. Paul) 8A Balto. Md. (837-4324)   |  |  |  |   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 4 - 1990  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson Randall   |  |   |  |  |  |   |  |   |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Rosa</i> ROSA MAE WALKER <i>Walker</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>4-1-90</i>   |  | 3. TIME OF DEATH<br><i>905A</i> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>577 30 1165</i>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>66</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>11/5/23</i>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>GEORGIA  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>MALCOLM GROW HOSPITAL   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>MORNINGSIDE   |  |
| 9c. COUNTY OF DEATH<br>PRINCE GEORGE   |  |  |  | 10a. STATE<br>DC  |  | 10b. COUNTY<br>NONE  |  |
| 10c. CITY, TOWN OR LOCATION<br>WASHINGTON DC   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><i>2948</i> CARLTON AVE NE   |  |
| 10f. ZIP CODE<br><i>20018</i>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>united states  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>BLACK  |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>08</i> College (1-4 or 5+) <i>DOMESTIC</i>  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>HOUSEKEEPING   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>TOMMIE WALKER   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>ROSIE INGRAM   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>MILTON W WALKER  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3700 HALLOWAY PL UPPER MARLBORO, MD  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>WASHINGTON NATIONAL   |  |  |  |
| 20c. LOCATION — City or Town, State<br>SUITLAND MD   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Alex S. Pope Jr.</i>  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br>ALEXANDER S POPE FUNERAL HOME 859<br>2617 PA AVE SE WASH DC 20020  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Intermittent cardiovascular disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a.<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |
| 24. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 25. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>28b. TIME OF INJURY<br>M<br>28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>28d. DESCRIBE HOW INJURY OCCURRED<br>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Augusto P. Rodriguez MD</i><br>29c. LICENSE NUMBER<br><i>D-21230</i><br>29d. DATE SIGNED (Month, Day, Year)<br><i>4-1-90</i>  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Augusto P. Rodriguez MD 5009 Bayburn Ct. Cp Jr. MD 20748</i>   |  |  |  | 31. DATE FILED (Month, Day, Year)<br><i>APR 4 1990</i><br>32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11-11-00



11-11-00

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Richard Theodore ZOLMAN  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March 30, 1990  |  | 3. TIME OF DEATH<br>1:50 p.m.  |  |
| 4. SOCIAL SECURITY NUMBER<br>213-09-0211   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (in yrs., last birthday)<br>75 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>11-9-1914  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>PENNSYLVANIA   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>FRANKLIN SQUARE HOSPITAL  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>ROSSVILLE   |  |
| 9c. COUNTY OF DEATH<br>Baltimore, Md Co.   |  |  |  | 10a. STATE<br>MARYLAND  |  | 10b. COUNTY<br>BALTIMORE   |  |
| 10c. CITY, TOWN OR LOCATION<br>DUNDALK   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>1405 VESPER AVENUE   |  |
| 10f. ZIP CODE<br>21222   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WW II   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE  |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>8TH GRADE  |  |  |  |
| 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>TURN FOREMAN   |  |  |  | 17. KIND OF BUSINESS/INDUSTRY<br>BETHLEHEM STEEL CORP.  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>JOHN ZOLMAN   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>JUSTINE WUNDER   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>MYRTLE V. ZOLMAN   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1405 VESPER AVENUE BALTIMORE, MARYLAND 21222   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>PARKWOOD CEMETERY 4-2-1990  |  |  |  |
| 20c. LOCATION — City or Town, State<br>BALTIMORE, MARYLAND   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br>DUDA-RUCK FUNERAL HOME OF DUNDALK, INC.<br>7922 WISE AVENUE DUNDALK, MARYLAND 21222  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Renal Failure<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. Pneumonia with Empyema<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. Coronary Artery Disease with Infarction<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br>M  |  |  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  |
| 29c. LICENSE NUMBER<br>D14030  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br>March 30, 1990   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Delos D Santos, MD 9000 Franklin Square Drive, Baltimore, Md 21237  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 4 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 08692

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROMEY ALLEN SR.</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 1 90</b>  |  | 3. TIME OF DEATH<br><b>M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>242-05-3227</b>   |  | 5. SEX<br><b>307 M 2 <input type="checkbox"/> F</b>  |  | 8. AGE (In yrs. last birthday)<br><b>77</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>12-22-12</b>                       |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>2509 EAST CHASE STREET</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>   |  |  |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><b>MD</b>   |  |  |  | 10b. COUNTY<br><b>BALTIMORE</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                              |  |
| 10d. INSIDE CITY LIMITS?<br><b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>  |  |  |  | 10e. STREET AND NUMBER<br><b>2509 E. CHASE STREET</b>  |  |  |  |
| 10f. ZIP CODE<br><b>21213</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  |
| 11. MARITAL STATUS<br><b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br/>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b><br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:</b> |  | 14. RACE — American Indian, Black, White, etc.<br><b>Specify: BLACK</b>      |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12th</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>LABORER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>BETHLEHEM STEEL CORP</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>HENRY ALLEN</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>NANNIE JONES</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CLARENCE ALLEN</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1530 SHEFFIELD ROAD/BALTIMORE, MD 21218</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br/>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ZION HILL BAPT CHURCH CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>LITTLETON, NC</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Bladys W. W. W.</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM. C. MARCH F.H. 1101 E. NORTH AVE.</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Large cancer with metastasis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>1. Some chronic condition long ago</b><br><b>2. History of severe disease</b><br><b>3. History of severe disease</b>   |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>  |  |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b> |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b><br>OTHER: <b>4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>  |  | 27. MANNER OF DEATH<br><b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined</b> |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |
| 29a. CERTIFIER (Check only one)<br><b>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>   |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Chi-Shiang Chen</b>   |  |  |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-2-90</b>                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Chi-Shiang Chen, M.D. 100 N. Broadway Baltimore, MD 21231</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 08693

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CHARLES ANDERSON</b>  |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>21</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>9 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX<br><b>1 M 2 F</b>   |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9/1/12</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)   |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><b>1 YES 2 NO</b>  |  |
| 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY  |  | 10e. STREET AND NUMBER<br><b>3203 Dorchester Road</b>   |  | 10f. ZIP CODE<br><b>21215</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 11. MARITAL STATUS<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><b>1 YES 2 NO</b><br>IF YES, GIVE WAR OR DATES                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 NO</b> Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>  |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) College (1-4 or 5+)</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Teacher</b> |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Retired</b>  |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Raymond Anderson</b>   |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Emma Simmons</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Palastine Anderson</b>  |  |  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3203 Dorchester Rd. Balto., MD. 21215</b> |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Garrison Forrest Vet.</b>                       |  | 20c. LOCATION — City or Town, State<br><b>Owings Mills, MD.</b>   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Dorthe Hector #281</b>   |  |  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>1721-27 E.L. Phillips Funeral Home N. Monroe</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br><b>a. cardiopulmonary arrest</b><br><b>b. atherosclerotic cardiovascular disease</b><br><b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br><b>c.</b><br><b>d.</b> |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alcohol</b>   |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 NO</b>  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 NO</b>  |  |  |  |   |  |   |  | 26. PLACE OF DEATH (Check only one)<br><b>1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)</b> |  |
| 27. MANNER OF DEATH<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>2/21/90</b>   |  | 28b. TIME OF INJURY<br><b>8:30 AM</b>   |  | 28c. INJURY AT WORK?<br><b>1 YES 2 NO</b>   |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Hit in MVA - driver of pickup</b>  |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                       |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>Settling</b>   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Joseph P. Grant MD</b>   |  |   |  |   |  |  |  |
|  |  | 29c. LICENSE NUMBER<br><b>D23981</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/21/90</b>   |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>3001 S. Narvon St Joseph P. Grant ER MD</b>  |  |  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>2 APR 5 1989</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Anderson-Randall</b>   |  |   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Charles Fike Allender</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 3, 1990</b>  |  | 3. TIME OF DEATH<br><b>3:30 A.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-05-9153</b>   |  | 5. SEX<br><b>1 M 2 F</b>   |  | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>7-23-1913</b>                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>27 Gwynn Lake Dr.</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Woodlawn</b>  |  | 9c. COUNTY OF DEATH<br><b>Baltimore County</b>                               |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Woodlawn</b>  |  | 10d. INSIDE CITY LIMITS?<br><b>1 YES 2 NO</b>                                |  |
| 10e. STREET AND NUMBER<br><b>27 Gwynn Lake Dr.</b>  |  |  |  | 10f. ZIP CODE<br><b>21207</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                  |  |
| 11. MARITAL STATUS<br><b>1 Never Married 2 X Married 3 Widowed 4 Divorced</b>   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 X NO</b><br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 X NO</b> Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 10 years + Business School</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Trucking Company &amp; Restaurant Owner</b> |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Self employed</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joseph Percy Allender</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Conda Fike</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Edna R. Allender</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>27 Gwynn Lake Dr. Baltimore, MD 21207</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Woodlawn, Maryland</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>John K. Agnew</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Rd. Randallstown, MD 21133</b>                     |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cardiorespiratory Arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Chronic Obstructive Pulmonary Disease + Emphysema</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. Congestive Heart Failure - Right side</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>d.</b> |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>Several</b><br><b>Years</b><br><b>Years</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes mellitus</b>  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 X NO</b>  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 X NO</b>   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 NO</b> |
| 27. MANNER OF DEATH<br><b>1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1 YES 2 NO</b>                                    |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |
| 29a. CERTIFIER (Check only one)<br><b>1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Herman Brecher M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>DO 1317</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/5/90</b>                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Herman Brecher M.D. 6410 Windsor Mill Rd Baltimore MD 21207</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 - 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-100000

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Travis AMERICO Anderson  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3-31-90   |  | 3. TIME OF DEATH<br>2:30PM M  |   |
| 4. SOCIAL SECURITY NUMBER<br>217-84-7587   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>14 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>10/28/75  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Route 543  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>FOREST HILL  |  | 9c. COUNTY OF DEATH<br>Harford County   |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |   |
| 10a. STATE<br>MARYLAND   |  | 10b. COUNTY<br>HARFORD   |  | 10c. CITY, TOWN OR LOCATION<br>ABINGDON   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>3635 B WOODSDALE ROAD  |  |  |  | 10f. ZIP CODE<br>21009  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>UNITED STATES  |   |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                                 |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>6   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>STUDENT   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>MIDDLE SCHOOL   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>GARY ALAN ANDERSON  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>BONNY MCLUCKIE   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>BONNY M. BOWLES  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3635 B. WOODSDALE ROAD ABINGDON, MD  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>DUBLIN MISSIONARY BAPTIST  |  | 20c. LOCATION — City or Town, State<br>DARLINGTON, MD   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>John A. Tillet  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>HARKINS FUNERAL HOME, INC. DELTA, PA  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple injuries<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE   |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Pending Investigation<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Could not be determined<br>5 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>3-31-90  |  | 28b. TIME OF INJURY<br>1:20PM   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |   |
| 28d. DESCRIBE HOW INJURY OCCURRED<br>Passenger in auto/fixed object  |  | 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)<br>Road   |  |   |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>Rt. 543/2823 Ady Road, Harford County, Maryland  |  | 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Ann M. Dixon, MD  |  |  |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>4-1-90   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Ann M. Dixon, MD 111 Penn Street, Baltimore, MD 21201   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>APR 5 - 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |  |   |   |   |   |   |   |  |
|--|--|---|---|--|---|---|---|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>ALBERTA M. ADAMS</i>  |  |   |   |  |   | 2. DATE OF DEATH<br>MONTH <i>4</i> DAY <i>2</i> YEAR <i>90</i>  |   | 3. TIME OF DEATH<br><i>6:10 AM</i>  |   |   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>216-12-2634</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><i>81</i> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS   |   | IF UNDER 24 HRS.<br>HOURS MIN.  |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>12-17-1908</i>                                     |   | 8. BIRTHPLACE (State or Foreign Country)<br><i>Balto. City</i>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>St. Joseph Hospital</i>   |  |   |   |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Towson</i>  |   |   | 9c. COUNTY OF DEATH<br><i>BALTIMORE</i> |   |  |
| RESIDENCE OF DECEDENT  |  |   |   |  |   |   |   |   |   |   |  |
| 10a. STATE<br><i>MD.</i>   |  | 10b. COUNTY<br><i>Baltimore</i>   |   | 10c. CITY, TOWN OR LOCATION<br><i>Towson</i>   |   |   |   | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |   |  |
| 10e. STREET AND NUMBER<br><i>509 E. Joppa Road</i>   |  |   |   | 10f. ZIP CODE<br><i>21204</i>  |   |   | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |   |   |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |   |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>White</i>                      |   |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>College (1-4 or 5+)</i>   |  |   |   | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Home Maker</i> |   |   | 16b. KIND OF BUSINESS/INDUSTRY  |   |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Wirtz</i>  |  |   |   |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Unknown</i>   |   |   |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Ellen V. Zawodny</i>  |  |   |   |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2606 Ivy Place Baltimore, Md.-21234</i> |   |   |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |   | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Holy REdeemer CEmentery</i>                           |   |   | 20c. LOCATION — City or Town, State<br><i>Baltimore, MD.</i>                                |   |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Kathleen J. Murphy</i>   |  |   |   |  |   | 22. NAME AND ADDRESS OF FACILITY<br><i>John C. Miller, Inc. 6415 Belair Road Baltimore, Md.-21206</i>                                       |   |   |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Sepsis</i><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <i>Pneumonia</i><br>b. <i>DUE TO (OR AS A CONSEQUENCE OF):</i><br>c. <i>DUE TO (OR AS A CONSEQUENCE OF):</i><br>d. <i>DUE TO (OR AS A CONSEQUENCE OF):</i> |  |   |   |  |   |   |   |   |   | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Liver failure, Urinary tract infection</i>  |  |   |   |  |   |   |   |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |   |   |   |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |   | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br><i>M</i>   |   | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED       |   |  |
|  |  |   | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                |   |   |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |   |  |   |   |   |   |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>M. [Signature]</i>   |  |   |   |  |   | 29c. LICENSE NUMBER   |   | 29d. DATE SIGNED (Month, Day, Year)<br><i>4/2/90</i>  |   |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>MILANIC STRONBONE 120 Sister Vincent Ave</i>   |  |   |   |  |   |   |   |   |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>APR 5 - 1990</i>   |  |   |   | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |   |   |   |   |   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.



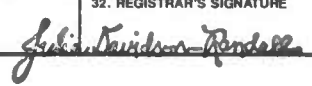
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1997-00

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Thomas C. Budzinski  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>4-2-90  |  | 3. TIME OF DEATH<br>2:33PM M   |  |
| 4. SOCIAL SECURITY NUMBER<br>220-50-4130   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>42 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>12/23/47                                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>1025 Cathedral Street  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |  | 9c. COUNTY OF DEATH  |  |
| RESIDENCE OF DECEDENT  |  |  |  | 10a. STATE<br>Maryland  |  | 10b. COUNTY  |  |
| 10c. CITY, TOWN OR LOCATION<br>Baltimore   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 10e. STREET AND NUMBER<br>1025 Cathedral Street  |  |  |  | 10f. ZIP CODE<br>21201  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: white                     |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+) 0  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Hair Stylist  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Hair  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Charles T. Jannings   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Myrtle V. Jones  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Frances L. Riddle  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2424 Raintree Avenue, Westminster, Md. 21157   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Garden of Faith Cemetery   |  | 20c. LOCATION — City or Town, State<br>Overlea, Maryland  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Ambrose Funeral Home, Inc.<br>1328 Sulphur Spring Road, Arbutus, Md. 21227  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  | Approximate Interval Between Onset and Death   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acquired immune deficiency syndrome<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>INSPECTION  |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>2 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>4-3-90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARGARITA A. KORELL, MD 111 Penn Street, Baltimore, MD 21201  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 5 1990  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HATTIE B. BROWN</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>1</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>6:10 P.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>579-32-6286</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan. 22, 1911</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>   |  |  |  |  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Regency Nursing Home</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Forestville</b>  |  | 9c. COUNTY OF DEATH<br><b>Prince George's</b>   |  |
| 10a. STATE<br><b>District of Columbia</b>   |  |  |  | 10b. COUNTY<br><b>Washington</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Washington</b>  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |   |  |
| 10e. STREET AND NUMBER<br><b>223 Newcomb Street, S.E.</b>   |  |  |  | 10f. ZIP CODE<br><b>20032</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th Grade</b> College (1-4 or 5+) <b>College</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Practical Nurse</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Health</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Thomas Holsey</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Marie Bonnet</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Cleopatra Lee</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>223 Newcomb St., S.E. Washington, D.C.</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Ft. Lincoln Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Brentwood, Maryland</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>John T. Stewart, III</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Stewart Funeral Home<br/>4001 Benning Rd., N.E. Wash. D.C.</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Motastic Endometrial cancer</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. |  |  |  | Approximate Interval Between Onset and Death<br><b>1 yr.</b>   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|   |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28d. DESCRIBE NOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>William T. Tanner, MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D35 206</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/3/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>William T. TANNER, MD 11701 Livingston Rd, Ft. WASH. MD 20744</b>   |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |                                   |   |   |
|--|--|--|--|---|-----------------------------------|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Inez Burger</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 2, 1990</b>  |                                   | 3. TIME OF DEATH<br><b>11:35A M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>227-26-5667</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>68</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>1-22-22</b>   |                                   | 8. BIRTHPLACE (State or Foreign Country)<br><b>VA.</b>  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Maryland General Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |                                   | 9c. COUNTY OF DEATH   |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |                                   |   |   |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>  |                                   | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>2222 PENNSYLVANIA AVENUE</b>  |  |  |  | 10f. ZIP CODE<br><b>21217</b>   |                                   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                         |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>High School</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Unemployed</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>NA</b>   |                                   |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>FRANK GRAY</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CALLIE</b>  |                                   |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CLAUDE BURGER</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2222 PENNSYLVANIA AVE./BALTIMORE, MD 21217</b>  |                                   |   |   |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MOUNT AUBURN CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>   |                                   |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Gladys Warner</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM. C. MARCH F.H. 1101 E. NORTH AVE.</b>   |                                   |   |   |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic carcinoma of the oropharynx</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><div style="display: flex; justify-content: space-between;"> <div>         a. DUE TO (OR AS A CONSEQUENCE OF):<br/>         b. DUE TO (OR AS A CONSEQUENCE OF):<br/>         c. DUE TO (OR AS A CONSEQUENCE OF):<br/>         d.       </div> <div>         Approximate Interval Between Onset and Death       </div> </div> |  |  |  |   |                                   |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Sepsis</b>  |  |  |  |   |                                   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
|  |  |  |  |   |                                   |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |                                   |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   | 28b. TIME OF INJURY<br><b>M</b>                  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   | 28d. DESCRIBE NOW INJURY OCCURRED |   |   |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |                                   |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |                                   |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Mohammad Aslam</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D28356</b>  |                                   | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/2/90</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Mohammad Aslam, M.D. c/o Maryland General Hospital</b>   |  |  |  |   |                                   |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Anderson</b>   |  |   |                                   |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Geraldine L. Ballard   |  |  |  | 2. DATE OF DEATH<br>MONTH 3 DAY 24 YEAR 90  |  | 3. TIME OF DEATH<br>1:00 p.m.  |  |
| 4. SOCIAL SECURITY NUMBER<br>579-30-1216   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>66 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>4/2/1923  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>North Carolina   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Montgomery General Hosp.  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Olney   |  |
| 9c. COUNTY OF DEATH<br>Montgomery  |  |  |  | 10a. STATE<br>District of Columbia  |  | 10b. COUNTY<br>Washington  |  |
| 10c. CITY, TOWN OR LOCATION<br>Washington  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>1911 D Street, N.E.  |  |
| 10f. ZIP CODE<br>20002   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>2 Years  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Cosmetologist   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Private  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Henry Lawrence  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Nannie Petway  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Kenneth Ballard  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1911 D St., N.E. Washington, D.C.  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Maryland National Cemetery  |  | 20c. LOCATION — City or Town, State<br>Laurel, Maryland  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>John T. Stewart, III  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Stewart Funeral Home<br>4001 Benning Rd., N.E. Wash. D.C.   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardio pulmonary Arrest<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>? Sepsis<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Atherosclerosis - PVD<br>Coronary Atherosclerosis |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Richard N. Scott, M.D.  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3/25/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>RICHARD N. SCOTT, M.D. 4801 MASS. AVE., N.W. WASH., D.C. 20016  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 5 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNIVERSITY OF CHICAGO

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Vincent P. Berger</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03/29/90</b>  |  | 3. TIME OF DEATH<br><b>4:00 A. M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>378 05 4458</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>5/8/07</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Loch Raven VA Medical Center</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>  |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><b>Md</b>   |  |  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>Ruxton Crossing #16 LA Costa Ct.</b>  |  | 10f. ZIP CODE<br><b>21204</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)  |  |
| 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>RET. LT. COL.</b>   |  |  |  | 17. KIND OF BUSINESS/INDUSTRY  |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>WILLIAM FREDERICK BERGER</b>   |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>WILHEMINA VOGT</b>  |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>ANGELETTE BERGER (spouse)</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Ruxton Crossing-#16 LA Costa Ct., Balto., Md. 21204</b>  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)   |  | 20c. LOCATION — City or Town, State  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i> <b>3-30-90</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>STATE ANATOMY BOARD, BALTO., MD. 21201</b>  |  |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>massive aspiration pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>CVA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br><b>days</b> |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Staph aureus septicemia</b>  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Michael Jablonsky MD</i>  |  | 29c. LICENSE NUMBER<br><b>MR0401</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/29/90</b>  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Michael Jablonsky MD, UNIV. OF MARYLAND HOSPITAL, 22 S. GREENE ST. BALTIMORE, MD</b>   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 1990</b><br><b>3/29/90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CORINE BRACEY</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>30</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>2:30 A.M.</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>212-48-2515</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>64</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>08-10-25</b>                                   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>BON SECOURS HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  | 9c. COUNTY OF DEATH<br><b>N/A</b>   |   |
| 10a. STATE<br><b>MARYLAND</b>  |  |  |  | 10b. COUNTY<br><b>N/A</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>23 NORTH MONROE STREET</b>   |  |   |   |
| 10f. ZIP CODE<br><b>21223</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |   |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>                  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input type="checkbox"/>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>BOOKER MEYER</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CARRIE MILES</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CHARLES MILLER</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1822 W. LOMBARD STREET (21223)</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ARBUTUS MEMORIAL PARK</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Sybil K. Jones</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>BROWN/THOMPSON F.H. P.O. BOX 4433</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. <b>Septic shock</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Renal failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate interval between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Sybil K. Jones</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D26256</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/2/90</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>BICH DUONG 1940 W. Baltimore St, Balto Md 21223</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 - 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>Sybil K. Jones</i>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BOOKER BLACK, JR.</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 2, 1990</b>  |  | 3. TIME OF DEATH<br>M<br><b>M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-38-5564</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>46</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>4/7/43</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SINAI HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9c. COUNTY OF DEATH<br><b>S. CAROLINA</b>  |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>BALTIMORE CITY</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>4310 PENHURST AVENUE</b>  |  |  |  | 10f. ZIP CODE<br><b>21215</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>BOOKER T. BLACK, SR.</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>PAULINE BLACK</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>PAULINE BLACK</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4310 PENHURST AVE. BALTO., MD. 21215</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>KING MEMORIAL PARK</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Leroy O. Dyett</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROY O. DYETT &amp; SON FUNERAL HOME<br/>4600 LIBERTY HEIGHTS AVENUE</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death)<br><b>Myocardial infarction</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Hypertensive Cardiovascular Disease</b> |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J. Alarofsky, MD</i>   |  | 29c. LICENSE NUMBER<br><b>DO 9839</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/5/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>4734 PARK HILLS AVE 21215</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 - 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Beasley, Markus</u>  |  |  |  | 2. DATE OF DEATH<br>MONTH <u>3</u> DAY <u>31</u> YEAR <u>90</u>   |  | 3. TIME OF DEATH<br><u>0251</u> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><u>215-60-2356</u>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><u>35</u> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>07-18-1954</u>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><u>Maryland</u>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><u>University of Maryland Hospital</u>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Baltimore</u>  |  |
| 9c. COUNTY OF DEATH<br>-----  |  |  |  | 10a. STATE<br><u>Maryland</u>   |  | 10b. COUNTY<br>-----   |  |
| 10c. CITY, TOWN OR LOCATION<br><u>Baltimore</u>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><u>2914 E. Federal Street</u>  |  |
| 10f. ZIP CODE<br><u>21213</u>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  | 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR OATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><u>Black</u>  |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) <u>12 yrs</u> College (1-4 or 5+) <u>1</u>  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>Warehouse Man</u>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Retail</u>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>Arthur Beasley</u>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Lucille Hubber</u>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>William Ellison, Jr.</u>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>2914 Federal Street, Baltimore, MD 21213</u>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Metro Crematory, Inc.</u>  |  |  |  |
| 20c. LOCATION — City or Town, State<br><u>Baltimore, MD</u>   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>George E. MacNabb</u>   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><u>Cremation Society of Maryland<br/>Baltimore, Maryland 21228</u>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Respiratory Arrest</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <u>Progressive multifocal Leukoencephalopathy</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>AIDS Demetia</u> |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>28b. TIME OF INJURY<br>M <u>1</u> <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Delma Beella</u>  |  |  |  | 29c. LICENSE NUMBER<br><u>3-31-90</u>   |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>22 S Greene St Balt MD</u>  |  |  |  |
| 31. DATE (Month, Day, Year)<br><u>APR 5 - 1990</u>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Rendell</u>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page number assigned by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |   |   |   |
|---|--|--|--|--|--|---|--|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Anna Virginia BERMEL  |  |  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>4/3/90  |  | 3. TIME OF DEATH<br>12/55 P M   |   |   |
| 4. SOCIAL SECURITY NUMBER<br>220-07-9516  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>77 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>12-18-12                                    |  | 8. BIRTHPLACE (State or Foreign Country)<br>Balto. Co.  |   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Franklin Square Hospital  |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Balto Co.                                      |  | 9c. COUNTY OF DEATH<br>Baltimore  |   |   |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |   |  |   |   |   |
| 10a. STATE<br>Md.   |  | 10b. COUNTY<br>Baltimore   |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |   |
| 10e. STREET AND NUMBER<br>9 Walnut Avenue   |  |  |  | 10f. ZIP CODE<br>21206   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                   |  |   |   |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>12th Grade   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Book Binder   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Dunn Heuisler & Sterling                            |  |   |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Harry C. Heuisler  |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary A. Krichton                 |  |   |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Ruby V. Heuisler  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9 Walnut Avenue Balto. Md.-21206  |  |   |  |   |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Parkwood cemetery  |  | 20c. LOCATION — City or Town, State<br>Baltimore Md.                                  |  |   |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>▶ Kathleen M. Murphy   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>John C. Miller, Inc. 6415 Belair Road<br>Baltimore, Md.-21206  |  |   |  |   |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebral Vascular Accident<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |   |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   | 28d. DESCRIBE HOW INJURY OCCURRED   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>164-1   |  | 29c. LICENSE NUMBER<br>1073   |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/3/90   |   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Peter Lopresti Md. 9000 Franklin Square Dr. Baltimore, Md. 21237   |  |  |  |  |  |   |  |   |   |   |
| 31. DATE FILED (Month, Day, Year)<br>APR 5 - 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Sofia Davidson-Randall  |  |   |  |   |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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ITEMS: 23, 27 per ME G-662  
4-25-90 cm

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |   |  |   |  |  |
|---|--|--|--|---|---|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Florence B. Carter  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3-29-90 FOUND   |   | 3. TIME OF DEATH<br>5:00PM M   |   |  |  |
| 4. SOCIAL SECURITY NUMBER<br>579-38-2651  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>62 YRS.   |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>11/17/1927                                 |   | 8. BIRTHPLACE (State or Foreign Country)<br>Wash. D.C.   |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br>1958 Rochelle Avenue  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>District Heights   |   |  | 9c. COUNTY OF DEATH<br>Prince Georges Co.   |  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |   |  |   |  |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Prince George's   |  | 10c. CITY, TOWN OR LOCATION<br>District Heights   |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |  |
| 10e. STREET AND NO NUMBER<br>1958 Rochelle Street   |  |  |  | 10f. ZIP CODE<br>20747  |   | 10g. CITIZEN OF WHAT COUNTRY?<br>United States                                       |   |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black                                 |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12)<br>12th Grade   |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Bureau of Engraving |   |   | 16b. KIND OF BUSINESS/INDUSTRY<br>Federal Government                                 |   |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>James L. Young   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Ann M. King  |   |  |   |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Stanley A. Carter   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6109 Belwood Street, District Heights, MD.   |   |  |   |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. Olivet Cemetery  |  |   | 20c. LOCATION — City or Town, State<br>Washington, D.C. |  |   |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>John T. Stewart, III   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Stewart Funeral Home<br>4001 Benning Rd., N.E. Wash. D.C.   |   |  |   |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>e. CHRONIC OBSTRUCTIVE PULMONARY DISEASE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |   |  |   | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input checked="" type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |   | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |   |  |   |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Frank Peretti, MD  |  |  |  | 29c. LICENSE NUMBER<br>OCME   |   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-30-90  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>FRANK PERETTI, MD 111 Penn Street, Baltimore, MD 21201 VC  |  |  |  |   |   |  |   |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 5 - 1990   |  |  | 32. REGISTRAR'S SIGNATURE<br>Sue Davidson-Randall  |   |   |  |   |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CHARLIE BOYD COLLINS</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 30 1990</b>   |  | 3. TIME OF DEATH<br>M  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>264-14-7894</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>65</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>June 11 1924</b>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Alabama</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>616 Glenview Ave.</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Glen Burnie</b>  |   |
| 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Anne Arundel</b>   |   |
| 10c. CITY, TOWN OR LOCATION<br><b>Glen Burnie</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>616 Glenview Ave.</b>   |   |
| 10f. ZIP CODE<br><b>21061</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4 or 5+) <b>None</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Military</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. ARMY</b>   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William A. Collins</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Laura L. Kent</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Catherine L. Collins</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as 10</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Arlington National Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Fort Meyer, Virginia</b>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Harold B. Pearson</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SINGLETON FUNERAL HOME<br/>1 SECOND AVE. S.W., GLEN BURNIE, MD. 21061</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Lung Cancer metastatic to Pleura and Skin</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |  |  |  | Approximate interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |   |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |   |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28e. DESCRIBE HOW INJURY OCCURRED  |  |  |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Thomas Horbath M.D.</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>027938</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/1/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>95 Aqueduct Rd. Glen Burnie, MD 21061</b>  |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 - 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | CERTIFICATE OF DEATH   |  |   |  | REG. NO.   |  |  |  |
|--|--|---|--|--|--|---|--|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MELVIN CROSBY</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>3</b> YEAR <b>90</b>   |  |   |  | 3. TIME OF DEATH<br><b>0805 M</b>                            |  |   |  |  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216 01 1274</b>  |  | 5. SEX<br><b>1</b> M <b>2</b> F   |  | 6. AGE (In yrs. last birthday)<br><b>89</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>3/28/01</b>                   |  | 8. BIRTHPLACE (State or Foreign)<br><b>MD.</b>               |  |   |  |  |  |  |  |
| 9a. FACILITY NAME (If not known, leave blank)<br><b>Balto Co General</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Balto</b>  |  |   |  | 9c. COUNTY OF DEATH<br><b>Balto</b>                          |  |   |  |  |  |  |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> YES <b>2</b> NO         |  |   |  |  |  |  |  |
| 10e. STREET AND NUMBER<br><b>501 W. Franklin Street</b>  |  |   |  | 10f. ZIP CODE<br><b>21201</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                  |  |   |  |  |  |  |  |
| 11. MARITAL STATUS<br><b>3</b> Widowed <b>1</b> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO<br>IF YES, GIVE WAR OR DATES                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> YES <b>2</b> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |  |  |   |  |  |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>UKn</b> |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |   |  |  |  |   |  |  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>UKn</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>UNK</b>  |  |   |  |  |  |   |  |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Stella Jones</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1701 Entwain Place 21217</b>                     |  |   |  |  |  |   |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Western Star Cem. Catonsville, Md.</b>         |  | 20c. LOCATION — City or Town, State<br><b>Catonsville, Md.</b>   |  |   |  |  |  |   |  |  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Joseph Miller</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>St. M. Miller F/H 1634 N. Broadway 21213</b>  |  |   |  |  |  |   |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RESPIRATORY FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>PNEUMONIA (MRSA)</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>CHF, COPD, CAD, HYPOTHYROIDISM &amp; ANEMIA; COLONIC CANCER</b> |  |   |  |  |  |   |  | Approximate interval Between Onset and Death<br><b>0 MIN</b> |  |   |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHF, COPD, CAD, HYPOTHYROIDISM &amp; ANEMIA; COLONIC CANCER</b>   |  |   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> YES <b>2</b> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> YES <b>2</b> NO |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> YES <b>2</b> NO   |  | HOSPITAL:<br><b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA   |  | OTHER:<br><b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)  |  | 26. PLACE OF DEATH (Check only one)                                     |  |  |  |   |  |  |  |  |  |
| 27. MANNER OF DEATH<br><b>1</b> Natural <b>5</b> Pending Investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><b>1</b> YES <b>2</b> NO                        |  | 28d. DESCRIBE HOW INJURY OCCURRED                            |  |   |  |  |  |  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |   |  |  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>C. Ravi MD</b>   |  | 29c. LICENSE NUMBER<br><b>D037333</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4.3.90</b> |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>C. Ravi MD, BCGH, RANDALLSTOWN, MD. 21133.</b>   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |  |  |   |  |  |  |   |  |  |  |  |  |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

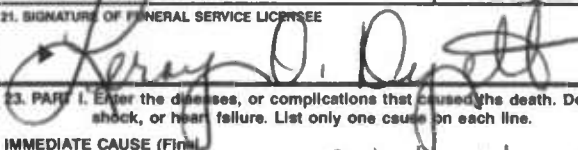
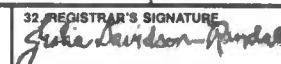
TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 08709

|  |  |  |  |  |  |   |  |   |  |   |  |
|--|--|--|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HALLIE CHUR N</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 3, 1990</b>   |  | 3. TIME OF DEATH<br>M                                 |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>137-14-9177</b>  |  | 6. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><b>87</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11/1/02</b> |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>VIRGINIA</b>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>MELNOR NURSING HOME</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>   |  |   |  | 9c. COUNTY OF DEATH   |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  |  |  | 10b. COUNTY<br><b>BALTIMORE CITY</b>   |  |   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>1117 N. STRICKER STREET</b>   |  |  |  | 10f. ZIP CODE<br><b>21217</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>                                |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 8+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ANNA CHURN</b>   |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>INDIANA JACKSON</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1117 N. STRICKER STREET: BALTO. MD 21217</b>   |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>WESTERN STAR CEMETERY</b>   |  |   |  | 20c. LOCATION — City or Town, State<br><b>CATONSVILLE, MARYLAND</b>                                       |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROY O. DYETT &amp; SON FUNERAL HOME<br/>4600 LIBERTY HEIGHTS AVENUE</b>   |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Metastatic Adenocarcinoma of Colon - with Metastases to Liver</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M                              |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Neal M. Friedlander, M.D.</b>  |  |  |  |  |  | 29c. LICENSE NUMBER<br><b>028673</b>                  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/3/90</b>  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>NEAL M. FRIEDLANDER, MD 333 ST. PAUL PLACE, SUITE 2A, BALTIMORE, MD 21202</b>  |  |  |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 - 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |  |   |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Booker T. Colter</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>2</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>10:22 a.m.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>239-16-8578</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>4/24/11</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>S. CAROLINA</b>  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>DEATON NURSING HOME</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  |
| 9c. COUNTY OF DEATH   |  |   |  | 10a. STATE<br><b>MARYLAND</b>   |  |   |  |
| 10b. COUNTY   |  |   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>  |  |   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br><b>DEATON NURSING HOME<br/>611 S. CHARLES STREET</b>  |  |   |  |
| 10f. ZIP CODE<br><b>21230</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 8+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>SYLVESTER STOKES</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>AGGIE COLTER</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ANNIE MORRIS</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2803 VIOLET AVENUE: BALTO., MD. 21215</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>WESTERN STAR CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>CATONSVILLE, MD.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Leroy O. Dyett</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROY O. DYETT &amp; SON FUNERAL HOME<br/>4600 LIBERTY HEIGHTS AVENUE</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Pressure sores</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Malnutrition</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. Cerebrovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d. Arteriosclerotic Cardiovascular Disease</b> |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Renal Insufficiency</b><br><b>Carcinoma of the Prostate</b>  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO             |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  |   |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO                                 |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                      |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>George Talar, M.D.</i>  |  | 29c. LICENSE NUMBER<br><b>D-19858</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/2/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>George Talar, M.D. 601 S. Charles St. Baltimore, Md. 21230</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rendall</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Roy Campbell</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>04-04-90</b>   |  | 3. TIME OF DEATH<br><b>11:30a M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-66-1469</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>33</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>09-25-1956</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>229 West Lanvale St. 21217</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH<br><b>----</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>-----</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>229 W. Lanvale Street</b>   |  |  |  | 10f. ZIP CODE<br><b>21217</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>12th</b><br>College (1-4 or 5+) <b>-----</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Style Director</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Hair Salon</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Eugene Campbell</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Louise Harle</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Jean Paul Chapon</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>229 W. Lanvale Street, Balto., MD 21217</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>George E. MacNabb</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Cremation Society of Maryland<br/>Baltimore, MD 21228</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Non Hodgkin's Lymphoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>HIV disease</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>3 mos</b><br><b>8 yrs</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>P. Powell</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>113006</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3 Apr 90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Thomas H. Powell, M. D. 101 W. Read Street, Baltimore, MD 21201</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 - 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ching L. Chin</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 - 1 - 90</b>  |  | 3. TIME OF DEATH<br><b>1:30 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-08-161</b>  |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>43</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>01/03/47</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>CHINA</b>  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>St Joseph Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |   |  | 10a. STATE<br><b>md</b>  |  | 10b. COUNTY<br><b>Anne Arundel</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Severna Park</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>37 Robinson Road</b>  |  |
| 10f. ZIP CODE<br><b>21146</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>CHINA</b>   |  | 11. MARITAL STATUS<br><b>1</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:   |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Oriental</b>  |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12th</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Cook</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Chinese Restaurant</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>"Unknown to Records"</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>"Unknown to Records"</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Shan C. Chao</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>794 Brackley Road, Severna Pk, MD 21146</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input type="checkbox"/> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>George E. MacNabb</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Cremation Society of Maryland<br/>Baltimore, MD 21228</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CARDIOPULMONARY ARREST</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Gastric Cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>15 min.</b><br><b>20 mo.</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO      |  |
| 26. PLACE OF DEATH (Check only one)<br><b>HOSPITAL:</b><br><b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br><b>OTHER:</b><br><b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>James Corcum MD</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D34084</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-1-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>James M. Corcum, St. Joseph's Hospital Towson MD 21204</b>  |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 - 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |   |   |
|--|--|---|--|---|--|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>EMMA MAY DISNEY  |  |   |  | 2. DATE OF DEATH<br>MARCH 31 1990   |  | 3. TIME OF DEATH<br>1830 P.M.   |   |   |
| 4. SOCIAL SECURITY NUMBER<br>220/36/8066D  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>88 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>April 27, 1901   |   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>436 Crain Highway NW   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Glen Burnie  |  | 9c. COUNTY OF DEATH<br>AA   |   |   |
| 10a. STATE<br>MD   |  | 10b. COUNTY<br>AA   |  | 10c. CITY, TOWN OR LOCATION<br>Glen Burnie  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |   |
| 10e. STREET AND NUMBER<br>436 Crain Highway NW   |  |   |  | 10f. ZIP CODE<br>21061  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |   |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+) 2  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home  |  |   |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Wesley Durner   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Henrietta Griffith   |  |   |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Lynn W. Vosloh   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1018 Shore View Circle Crownsville, MD 21032   |  |   |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Glen Haven Memorial Park  |  | 20c. LOCATION — City or Town, State<br>Glen Burnie, MD  |  |   |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Singleton Funeral Home<br>1 Second Ave SW Glen Burnie, MD 21061   |  |   |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |   | Approximate Interval Between Onset and Death  |   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE CORONARY INSUFFICIENCY<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |   |   |   |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |   |   |
| c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.  |  |   |  |   |  |   |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |   |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |   |  | 29c. LICENSE NUMBER<br>033757   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-31-90  |   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>CITARLES A. SEAGER<br>108 ASKEWTON ROAD SEVENNA PARK MD   |  |   |  |   |  |   |   |   |
| 31. DATE FILED (Month, Day, Year)<br>APR 5 1990  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MAURICE - DECOSTER</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>03</b> DAY <b>30</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>3 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>098-14-7860</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>86</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec. 11, 1903</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Belgium</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Fernwood House</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Bethesda, Maryland</b>                                      |  |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Montgomery</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Chevy Chase</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>4701-Willard Avenue, #527</b>  |  |
| 10f. ZIP CODE<br><b>20815</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  |   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                            |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (14 or 5+) <b>10</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Postal Clerk</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>City Post Office</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Julius Herrewyn</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elisabeth Decoster</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Howard P. Wright (Per. Rep.)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4701-Willard Ave., #527, Chevy Chase, Maryland 20815</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Lee's Crematory</b>   |  | 20c. LOCATION — City or Town, State<br><b>Washington, D.C.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Charles L. Bilanger</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>J. William Lee's Sons Company Funeral Home<br/>300-4th St., NE, Washington, D.C. 20002-5816</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>emphysema</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |  |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>peripheral vascular disease with occlusion left femoral artery</b>   |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                      |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>James H. Brodsky</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D-20297</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-30-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>James H. Brodsky, MD 4701 Willard Ave Chevy Chase MD 20815</b>  |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Mary P. Day</i>   |  |   |  | 2. DATE OF DEATH<br>MONTH <i>4</i> DAY <i>2</i> YEAR <i>1990</i>  |  | 3. TIME OF DEATH<br><i>9:45 A M</i>   |   |
| 4. SOCIAL SECURITY NUMBER<br><i>217-26-2000</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><i>93</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>3/23/1897</i>                                  |   |
| 8. FACILITY NAME (If not institution, give street and number)<br><i>BEL AIR CONVALESCENT CENTER</i>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>BEL AIR</i>   |  | 9c. COUNTY OF DEATH<br><i>HARFORD</i>   |   |
| 10a. STATE<br><i>MD</i>  |  |   |  | 10b. COUNTY<br><i>HARFORD</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>DARLINGTON</i>  |   |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br><i>3420 DUBLIN ROAD</i>   |  |   |   |
| 10f. ZIP CODE<br><i>21034</i>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>WHITE</i>                     |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>7</i> College (1-4 or 5+) <i></i>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>HOUSEWIFE</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>WILLIAM T. DICK</i>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>TILLIE POHLAR</i>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>WILLIAM E. DAY</i>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>3420 DUBLIN RD., DARLINGTON, MD., 21034</i>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>DUBLIN SOUTHERN</i>  |  | 20c. LOCATION — City or Town, State<br><i>DARLINGTON, MD.</i>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John H. Telleff</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>HARKINS F.H. INC., 600 MAIN ST. DELTA, PA</i>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>cardiorespiratory arrest</i><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><i>deep infection</i><br><i>urosepsis</i> |  |   |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>paralysis</i>   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John H. Telleff MD</i>   |  |   |  | 29c. LICENSE NUMBER<br><i>D28136</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>4-2-90</i>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><i>APR 5 - 1990</i>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Gina Davidson-Randall</i>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.







MEMO FROM

Kathy Morris

11/20/90

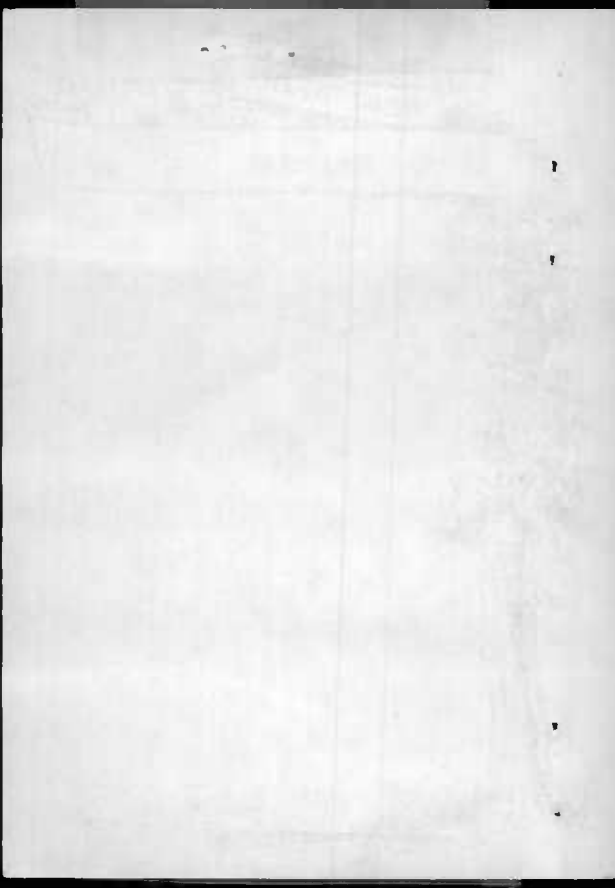
Do not Issue any  
Copies of this death!

SEE KATHY MORRIS FIRST!

(ck. blk.folder)

4-2-90

08716



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>RONALD W. DEISE</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 2, 1990</b>  |  | 3. TIME OF DEATH<br><b>10:25P</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-40-0041</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>48</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>7-29-41</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE CITY</b>  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>17 Greenwood Avenue</b>   |  |  |  | 10f. ZIP CODE<br><b>21206</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                          |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>6 yrs.</b>   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Cost Appliance Mgr. Finance Dept.</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Shephard Pratt Hosp.</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Wm. Franklin Deise</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mildred Emily Hora</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>William F. Deise</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17 Greenwood Avenue Baltimore, Maryland-21206</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gardens of Faith Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Kathleen H. Murphy</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>John C. Miller, Inc. 6415 Belair Road Baltimore, Md.-21206</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |   |  |   |  |
| a. <b>Respiratory Failure</b>  |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| b. <b>Hodgkins Disease</b>   |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| c. _____   |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| d. _____   |  |  |  |   |  |   |  |
| Approximate Interval Between Onset and Death<br><b>2 weeks</b><br><b>4 yrs.</b>  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Elizabeth J. Lee MD</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>MD D38653</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-2-90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>William Barton, MD 600 N. Wolfe St. Baltimore, MD</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 - 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Henderson</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Robert Eads - (Eades)</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>1</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>449 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-14-0703</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>3 15 1911</b>   |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Mercy Medical Center</b>   |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 8c. COUNTY OF DEATH<br><b>N/A</b>   |  |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>N/A</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore City</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>11 N. Fulton Ave.</b>  |  |   |  |
| 10f. ZIP CODE<br><b>21223</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                               |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Freight handler</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Trucking Company</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Ernest Eads</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Marie Bowie</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ava Hedgeforth</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>WESTERN STAR CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTO., Md.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Lynette K. Jones</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>BROWN-THOMPSON F.H. P.O. BOX 4433</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Gastrointestinal Bleeding</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>Bleeding Duodenal Ulcer</b><br>c.<br>d. |  |  |  |   |  | Approximate interval between Onset and Death<br><b>2 weeks.</b>                                       |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia - Alzheimer's</b>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide <input type="checkbox"/><br>4 <input type="checkbox"/> Homicide <input type="checkbox"/>  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO           |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Martin Brander MD</b>   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-1-90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARTIN BRANDER MD Mercy Medical Center Baltimore Md 21202-2165</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 - 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Jake Davidson</b>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MABEL FAYE FULLER  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3 17 90   |  | 3. TIME OF DEATH<br>3:15A M  |  |
| 4. SOCIAL SECURITY NUMBER<br>005-24-3696   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>76 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>9/14/14   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>MAINE  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>258 ULLMAN ROAD  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>ANNEXARMMX PASADENA  |  | 9c. COUNTY OF DEATH<br>ANNE ARUNDEL  |  |
| 10a. STATE<br>MD.  |  | 10b. COUNTY<br>ANNE ARUNDEL  |  | 10c. CITY, TOWN OR LOCATION<br>PASADENA   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>258 ULLMAN ROAD  |  |  |  | 10f. ZIP CODE<br>21122  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>FRANK LOVELY  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>ANN ROLLINS  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>BARBARA DREWS  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6 Gerald Ct., Severn, Md. 21144  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)   |  | 20c. LOCATION — City or Town, State   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Sammy Miller</i> 3-20-90   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>STATE ANATOMY BOARD, BALTO., MD. 21201  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Malignant brain tumor</i><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>I had not seen her for some time or even after death. I was the only physician contacted on her death.</i>  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <i>Hospice?</i>  |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Joseph Solomon MD</i>  |  |  |  | 29c. LICENSE NUMBER<br>D17126   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3/27/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>JOSEPH SOLIMAN MD   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>3/27/90   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be obtained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>James Luther Fitch</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>2</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>11:30</b> P M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-01-7263</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11-23-1901</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Joseph Richey House</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  |
| 9c. COUNTY OF DEATH<br><b>-----</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>-----</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>2314 W. Patapsco Avenue</b>   |  |
| 10f. ZIP CODE<br><b>21230</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 8+) <b>-----</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Tailor</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Tailor</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Walter Fitch</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Katherine Gross</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Marie D. Fitch</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2314 W. Patapsco Avenue, Balto., MD 21230</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>George E. MacNabb</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Cremation Society of Maryland<br/>Baltimore, Maryland 21228</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |   |  |  |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Cachexia</b>   |  |  |  |   |  | <b>2 mos</b>   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Hepatoma and Prostatic Carcinoma</b>   |  |  |  |   |  | <b>8 mos</b>   |  |
| d. SEQUENTIALLY LIST CONDITIONS, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Hospice</b> |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Robert C. Irwin M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D08900</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-3-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Robert C. Irwin, M.D. 828 N. Eutaw St. Balto. Md. 21201</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 - 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Josephine G. Gunther   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>04 05 90  |  | 3. TIME OF DEATH<br>5:40 a.m. <sup>M</sup>  |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>89 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>11/22/1900  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Towson Nursing Center  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Towson   |  | 9c. COUNTY OF DEATH<br>Baltimore  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Baltimore   |  | 10c. CITY, TOWN OR LOCATION<br>Timonion   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>2408 Eastridge Road  |  |  |  | 10f. ZIP CODE<br>21093  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: white                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Telephone operator  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Telephone Co.   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Frank Ruffner   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Ceclia B. Songer   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Virginia Conoscenti  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2408 Eastridge Road, Timonion, Md. 21093   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Meadowridge Memorial Park  |  | 20c. LOCATION — City or Town, State<br>Dorsey, Maryland   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Ambrose Funeral Home, Inc.<br>1328 Sulphur Spring Road, Arbutus, Md 21227   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
| Sequitely illat conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  | b. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Dying Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)   |  |   |  | 28e. DESCRIBE HOW INJURY OCCURED  |  |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |
| 29. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29a. SIGNATURE AND TITLE OF CERTIFIER  |  |  |  | 29c. LICENSE NUMBER<br>D-09383  |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/5/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Charles F O'Donnell MD - 7501 York Rd - Towson Md   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 5 1990  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DEBORAH A. GREENE</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>31</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>9:50pm</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>212-60-7066</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>37</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>7-28-52</b>                                  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>LIBERTY MEDICAL CENTER</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>   |  | 9c. COUNTY OF DEATH  |   |
| 10a. STATE<br><b>MD</b>  |  |  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>                                   |   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>2794 THE ALAMEDA</b>  |  |  |   |
| 10f. ZIP CODE<br><b>21218</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>             |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>NA</b>  |  | 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>UNEMPLOYED</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>FRANKLIN JOHNSON</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ALMA CONYERS</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ALMA JOHNSON</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2794 THE ALAMEDA/BALTIMORE, MD 21218</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Baltimore Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD</b>  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Bladys Warren</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>   |  |  |   |
| 23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b><br><br>Sequently that conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <b>HUMAN IMMUNODEFICIENCY VIRUS</b> </div> <div style="width: 65%;"> DUE TO (OR AS A CONSEQUENCE OF):<br/> DUE TO (OR AS A CONSEQUENCE OF):<br/> DUE TO (OR AS A CONSEQUENCE OF):<br/> DUE TO (OR AS A CONSEQUENCE OF): </div> </div> |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)   |   |
| 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Nell Kimmel MD</b>   |  |  |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/31/90</b>                                  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |  |   |   |
|---|--|--|---|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>DORRIS DUANE GRAGER   |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 30 90   |  | 3. TIME OF DEATH<br>5:27 p.m.   |   |
| 4. SOCIAL SECURITY NUMBER<br>178.28.7949  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>52 YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br>NOV. 29, 1937  |  | 8. BIRTHPLACE (State or Foreign Country)<br>PENNSYLVANIA  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>NORTH ARUNDEL HOSPITAL  |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>GLEN BURNIE  |  | 9c. COUNTY OF DEATH<br>ANNE ARUNDEL   |   |
| RESIDENCE OF DECEDENT   |  |  |   |   |  |   |   |
| 10a. STATE<br>MARYLAND  |  | 10b. COUNTY<br>ANNE ARUNDEL  |   | 10c. CITY, TOWN OR LOCATION<br>HANOVER  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>170 CHESAPEAKE COURT  |  |  |   | 10f. ZIP CODE<br>21076  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                                    |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 <sup>th</sup><br>College (1-4 or 5+) NONE  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>TRUCK DRIVER                    |   | 16b. KIND OF BUSINESS/INDUSTRY<br>JOHN W. RITTER TRUCKING INC.  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>WILLIAM ANDREW GRAGER SR.  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>WYNONA BELL TAYLOR   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>LILLIAN GRAGER  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>21076<br>170 CHESAPEAKE COURT COURT HANOVER, MARYLAND  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>MEADOWRIDGE MEM. PK.   |   | 20c. LOCATION — City or Town, State<br>ELKRIDGE, MARYLAND   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James J. Suber</i>  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>SINGLETON<br>1 SECOND AVE S.W. GLEN BURNIE, MARYLAND<br>21061   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiopulmonary arrest</i><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><i>Has history of Coronary artery disease and history of previous angioplasty</i> |  |  |   |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |   |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 27. DATE OF INJURY (Month, Day, Year)  |   | 28. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |   |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>James D. Clarke, M.D.</i>  |   | 29c. LICENSE NUMBER<br>D31476   |  | 29d. DATE SIGNED (Month, Day, Year)<br>4-1-90.  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br>James D. Clarke M.D. 341 N. Calvert Street Baltimore, MD 21202 547-1885   |  |  |   |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>APR 5 - 1990   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rendell</i>   |   |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LENA MARIAN GREENSTREET</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>04</b> DAY <b>03</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>2221 hr</b> M   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>212-28-8000</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9/7/1908</b>                               |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Harbor Hospital Center</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 9c. COUNTY OF DEATH<br><b>N/A</b>  |   |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY<br><b>N/A</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore City (Brooklyn)</b>                      |   |
| 10e. STREET AND NUMBER<br><b>3712 Sixth Street,</b>  |  |  |  | 10f. ZIP CODE<br><b>21225</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>           |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4th</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Housewife</b>  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Stanislaus Fado</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Michalena ----</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Joyce L. Frazier</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3712 Sixth St., Baltimore, Maryland 21225</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Kevin E. Ecker</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>McCully Funeral Home of Brooklyn<br/>237 East Patapsco Ave., Balto., Md. 21225</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>bilateral pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |   |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>septic shock = ACIDOSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |   |
| <b>cardiac arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>non insulin dependent - diabetic mellitus</b><br><b>Alzheimer's dis</b><br><b>pancytopenia</b>  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>R. Small M.D.</b>  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/3/90</b>                                 |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>HARBOR HOSP CENT-R 3001 S. HANOVER BALT Md 21220</b>   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 - 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Shirley Harrison-McDell</b>  |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Robert Gray   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>April 1, 1990  |  | 3. TIME OF DEATH<br>M   |  |
| 4. SOCIAL SECURITY NUMBER<br>213-05-9220  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>82 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>6-8-1908   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>102 Purvis Place  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Pikesville  |  | 9c. COUNTY OF DEATH<br>Baltimore County   |  |
| RESIDENCE OF DECEDENT   |  |   |  |  |  |   |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Baltimore County   |  | 10c. CITY, TOWN OR LOCATION<br>Pikesville  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>102 Purvis Place  |  |   |  | 10f. ZIP CODE<br>21208   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>8th Grade   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Cab Driver   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Yellow Cab  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Robert J. Gray   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Nellie Jane Morrison  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Nancy Tillson  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>102 Purvis Place Pikesville, MD 21208   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Kriders Cemetery  |  | 20c. LOCATION — City or Town, State<br>Westminster, MD   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>John K. Agnew  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Loring Byers Funeral Directors, Inc.<br>8728 Liberty Rd. Randallstown, MD 21133  |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>- Respiratory Failure<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>- Natural Cause<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>- None |  |   |  |  |  |   | Approximate Interval Between Onset and Death |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>[Signature]  |  |   |  | 29c. LICENSE NUMBER<br>D14753  |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/13/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>8620 Liberty Road, Randallstown, MD 21133  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 5 - 1990   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Margaret Hawthorne</u>  |  |  |  | 2. DATE OF DEATH<br>MONTH <u>04</u> DAY <u>01</u> YEAR <u>90</u>  |  | 3. TIME OF DEATH<br><u>10:50A</u> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><u>212-03-0466</u>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><u>83</u> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>4/27/06</u>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><u>DULANEY VALLEY NURSING HOME</u>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>TOWSON</u>  |  | 9c. COUNTY OF DEATH<br><u>BALTIMORE</u>   |  |
| 10a. STATE<br><u>MD.</u>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><u>BALTIMORE CITY</u>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><u>524 N. CHARLES ST. - APT. 510</u>   |  |  |  | 10f. ZIP CODE<br><u>21201</u>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><u>WHITE</u>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><u>Elementary/Secondary (0-12)</u>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>College (1-4 or 5+)</u>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>CHARLES SCHANZE</u>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>ALVERTA LIST</u>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>MARY MAIONE (sister)</u>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>509 Towson Ave., Lutherville, Md. 21093</u>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)   |  | 20c. LOCATION — City or Town, State   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>[Signature]</u> <u>4-3-90</u>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>STATE ANATOMY BOARD, BALTO., MD. 21201</u>   |  |   |  |
| 23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Sudden death</u><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <u>Submucosal Embolus</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>ASCVD</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death: <u>5 yrs</u> |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><u>M</u>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>[Signature]</u>  |  |  |  | 29c. LICENSE NUMBER<br><u>D-09383</u>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>4/1/90</u>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>Charles F. O'Donnell MD - 7501 York Rd - Towson MD</u>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><u>APR 3 - 1990</u>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 00152

ITEMS: 23 third 281 per ME G-662  
4-20-90 cm

01235

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BERNARD HICKSON</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-20-90</b>   |  | 3. TIME OF DEATH<br><b>6:42AM</b> M  |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>59</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10/20/30</b>   |  | 8. BIRTHPLACE (State or Foreign Country)   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Exeter Street &amp; Watson Court</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>   |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><b>MD.</b>   |  |   |  | 10b. COUNTY<br><b>BALTIMORE CITY</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br><b>4211 PARK HEIGHTS AVE .</b>   |  |  |  |
| 10f. ZIP CODE  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (8-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>in-state removal</b>  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)  |  | 20c. LOCATION — City or Town, State  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>STATE ANATOMY BOARD, BALTO., MD. 21201</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ALCOHOL INTOXICATION COMPLICATED BY HYPOTHERMIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |  |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>   |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>3-20-90</b>   |  | 28b. TIME OF INJURY<br><b>6:38AM</b>   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>FOUND UNCONSCIOUS</b>   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>FOUND IN OUTDOOR COURTYARD</b>  |  |  |  |
| 28f. LOCATION (Street and Number, or Rural Route Number, City or Town, State)<br><b>EXETER ST. AND WATSON COURT BALTIMORE CITY, MARYLAND</b>   |  |   |  | 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |   |  | 29c. LICENSE NUMBER<br><b>OCME</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-20-90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARGARITA A. KORELL, MD 111 Penn Street, Baltimore, MD 21201</b> vd  |  |   |  |  |  |  |  |
| 31. DATE (Month, Day, Year)<br><b>APR 3 - 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the physician or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EDWARD O. HARRIS</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>3</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>250 A.M.</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>215 05 5251</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 8. AGE (in yrs. last birthday)<br><b>80</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Aug. 26, 1909</b>                              |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>ST. JOSEPH Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>TOWSON</b>  |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>   |   |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY<br><b>Howard County</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Ellicott City</b>   |   |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>7960 Old Montgomery Road</b>   |  |   |   |
| 10f. ZIP CODE<br><b>21043</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 years</b><br>College (1-4 or 5+) <b>College (1-4 or 5+)</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Cabinet Maker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Fire Department</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles M. Harris</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Theolinda W. Roberts</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary Margaret Paddy</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5413 Knell Avenue, Baltimore, Maryland 21206</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Meadowridge Memorial Park</b>   |  | 20c. LOCATION — City or Town, State<br><b>Dorsey Maryland</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Burgee-Henss</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Burgee-Henss Funeral Home<br/>3631 Falls Road, Baltimore, Maryland 21211</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPSIS</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><b>PNEUMONIA</b><br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br><br><br>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Francis T. Khoo, STAFF MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 30263</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-3-90</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>FRANCIS T. KHOO, ST. JOSEPH HOSPITAL</b>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 - 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b>  |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DOROTHY FRANCES HUDSON</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 2 1990</b>   |  | 3. TIME OF DEATH<br><b>5:34 p.m.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-01-6004</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>AUG. 1 1912</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>North Arundel Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Glen Burnie</b>   |  | 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Anne Arundel</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Glen Burnie</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>7900 Benesch Circle Apt. 809</b>  |  |  |  | 10f. ZIP CODE<br><b>21061</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4 or 5+) <b>None</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT use retired.)<br><b>Sales</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Department Store</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Jefferson Davis Roten</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Annie Frances Carrell</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Samuel M. Hudson</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as 10</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Peters Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Queenstown, Maryland</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Harold B. Hudson</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SINGLETON FUNERAL HOME<br/>1 SECOND AVE. S.W., GLEN BURNIE, MD 21061</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Acute cerebral vascular Accident</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Acute Pulmonary Emboli</b>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John F. Robbins</i>  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/3/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>GLEN F. ROBBINS, M.D. 1600CRAIN HIGHWAY SW #302, GLEN BURNIE, MARYLAND 21061</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 - 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Iola Virginia Higdon  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3 26 90  |  | 3. TIME OF DEATH<br>10:06 AM  |  |
| 4. SOCIAL SECURITY NUMBER<br>578-66-9645  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>92 23 YRS.  |  |
| 7. DATE OF BIRTH (Month, Day, Year)<br>June 27, 1897  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Bristow, Virginia  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>S.O. Maryland Hospital  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Clinton   |  | 9c. COUNTY OF DEATH<br>P-B. County  |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Washington, D.C.  |  | 10c. CITY, TOWN OR LOCATION<br>Washington, D.C.   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>1814-C Street, Northeast   |  | 10f. ZIP CODE<br>20002  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br>United States  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify.   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Housewife  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>at home   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Sanford Allen Payne  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Augusta S. Payne  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>James S. Higdon, JR. (Son)  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3907-Canterbury Way, Temple Hills, Maryland 20748   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Fort Lincoln Cemetery  |  | 20c. LOCATION — City or Town, State<br>Brentwood, Maryland  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Charles L. Belanger  |  | 22. NAME AND ADDRESS OF FACILITY<br>J. William Lee's Sons Company Funeral Home<br>300-4th St., NE, Washington, D.C. 20002-5816   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. Congestive Heart Failure<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Metastatic Malignant Melanoma<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  | Approximate Interval Between Onset and Death<br>2 weeks<br>Years   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Mitral Regurgitation<br>Renal insufficiency   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO         |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 8 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Elizabeth J. Engelhardt MD  |  | 29c. LICENSE NUMBER<br>D 36794  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br>3/26/90  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Elizabeth J. Engelhardt MD 9131 Piscataway Rd, #600, Clinton, MD 20735  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 5 - 1990   |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 JPL

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Sarah Johnson</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 - 20 - 90</b>  |  | 3. TIME OF DEATH<br>HOURS MIN. SEC.<br><b>5:20 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>66</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>4/10/23</b>  |  | 8. BIRTHPLACE (State or Foreign Country)  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SUBURBAN HOSPITAL</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BETHESDA</b>   |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |  |
| 10a. STATE<br><b>MD.</b>  |  | 10b. COUNTY<br><b>MONTGOMERY</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>BETHESDA</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>5721 GROSVENOR LANE</b>  |  |   |  | 10f. ZIP CODE<br><b>20814</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)                         |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Charlesetta Dillon (sister)</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1370 Peabody St., N.W., Wash., D.C.</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>in-state removal</b>  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)  |  | 20c. LOCATION — City or Town, State  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Donald D. Wace</b> 4-3-90   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>STATE ANATOMY BOARD, BALTO., MD. 21201</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Bilateral Bronchopneumonia</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Cerebrovascular Accidents</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><b>my H pylori</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus</b>  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John Tauber MD</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>D08946</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-21-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John Tauber 8218 Wisconsin Ave Bethesda</b>   |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 - 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Sarah Johnson-Randall</b>  |  |   |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Pattie B. Jones</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>2</b> YEAR <b>1990</b>   |  | 3. TIME OF DEATH<br><b>14.50</b> M   |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Feb. 6, 1919</b>   |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><b>St. Agnes Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><b>MD.</b>   |  |  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>713 Grantley Street</b>   |  | 10f. ZIP CODE<br><b>21229</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES       |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)                                    |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>C.B. Baskerville</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lonnie Bracey</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Jonas Jones</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>713 Grantley Street Baltimore, Maryland 21229</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Garrison Forrest Vet.</b>   |  | 20c. LOCATION — City or Town, State<br><b>Owings Mills, MD.</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Donatha Hector #281</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>E.L. Phillips Funeral Home N. Monroe St. 1721-27</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrest</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>Pulmonary Embolism</b><br>c. <b>Multiple Myeloma</b><br>d. <b>Chronic Renal Failure</b> |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
|  |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Selma Inel, M.D.</b>   |  |  |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/02/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Selma Inel SAH #297</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>4/2/90 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |   |   |
|---|--|---|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JULIA LICHAROWICZ</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 4 1990</b>  |  | 3. TIME OF DEATH<br>M<br><b>M</b>                                       |   |
| 4. SOCIAL SECURITY NUMBER<br><b>215-05-1797</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>6-11-06 1906</b>              |   |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>4006 BEE CT.</b>   |  |   |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>WESTMINSTER</b>  |  | 8c. COUNTY OF DEATH<br><b>CARROLL</b>                                   |   |
| 10a. STATE<br><b>MD</b>   |  |   |  | 10b. COUNTY<br><b>CARROLL</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>WESTMINSTER</b>                       |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |  |  |   |   |
| 10e. STREET AND NUMBER<br><b>4006 BEE CT.</b>   |  |   |  | 10f. ZIP CODE<br><b>21157</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                             |   |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5th</b> College (1-4 or 5+) <b>SEAMSTRESS</b>  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ANDREW LICHAROWICZ</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>VICTORIA GRUTKOWSKI</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CAROL ANN NICHOLSON</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4006 BEE CT WESTMINSTER MD 21157</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>HOLY ROSARY CEMETERY BALTO. MD.</b>   |  | 20c. LOCATION — City or Town, State                                     |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Edward J. Weger</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>EDWARD J. WEGER 4015 Chester St.</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CONGESTIVE HEART FAILURE</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF): <b>CAD</b><br>b. DUE TO (OR AS A CONSEQUENCE OF): <b>HVD</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |  |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus</b>  |  |   |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |  |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Homicide   |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>MANUELA J. SEVILLA MD</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>018099</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-6-90</b>                    |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MANUELA J. SEVILLA 611 N. W. 2nd St - WESTMINSTER</b>   |  |   |  |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>4-4-APR 5 - 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Paul Joseph Lorant  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>04 02 90  |  | 3. TIME OF DEATH<br>3 45 P.M.  |   |
| 4. SOCIAL SECURITY NUMBER<br>058-26-6741  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>76 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>06-23-1913                                 |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Yugoslavia  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>1001 St. Paul Street Apt. 4c  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore                                     |   |
| 9c. COUNTY OF DEATH<br>-----  |  |  |  | 10a. STATE<br>New York  |  | 10b. COUNTY<br>-----   |   |
| 10c. CITY, TOWN OR LOCATION<br>Forest Hills   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |   |
| 10e. STREET AND NUMBER<br>93-03 69th Avenue   |  |  |  | 10f. ZIP CODE<br>11375  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>College (1-4 or 5+)<br>5 +   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Design Engineer   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Ship Building   |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Eugene Weiss   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Olga Kraus   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Clara B. Lorant   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>93-03 69th Ave. Forest Hill, N. Y. 11375   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Metro Crematory, Inc.  |  | 20c. LOCATION — City or Town, State<br>Baltimore, MD  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>George E. MacNabb  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Cremation Society of Maryland<br>Baltimore, MD 21228  |  |  |   |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinoma of Prostate with metastases<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br>1 year  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
|   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
|   |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Louis S. Grenzer MD   |  |   |  |  |   |
|   |  | 29c. LICENSE NUMBER<br>D01442  |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/2/90   |  |  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Louis E. Grenzer M.D. 1101 N. Calvert St. Bk. 14 21202   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>APR 5 - 1990   |  | 32. REGISTRAR'S SIGNATURE<br>John A. Anderson  |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOSEPH F. MCCANN</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 1, 1990</b>  |  | 3. TIME OF DEATH<br>M<br><b>6:45A</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>209 12 5926</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>67</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11-25-22</b>                                      |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>PERRY POINT HOSPITAL</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CECIL</b>   |  | 9c. COUNTY OF DEATH<br><b>CECIL</b>   |   |
| 10a. STATE<br><b>MD.</b>  |  |  |  | 10b. COUNTY<br><b>CECIL</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>PERRYVILLE</b>  |   |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>724 AIKEN AVE.</b>   |  |   |   |
| 10f. ZIP CODE<br><b>21903</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>RET. PURCHASING AGENT</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>GABRIEL MCCANN</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>FRANCES GREEN</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JEAN MCCANN (wife)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>724 Aiken Ave., Perryville, Md. 21903</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)   |  | 20c. LOCATION — City or Town, State   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i> <b>4-3-90</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>STATE ANATOMY BOARD, BALTO., MD. 21201</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Atherosclerotic heart disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>b. Hepatic cirrhosis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. Hepatic encephalopathy</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d. Recent upper gastrointestinal bleed</b> |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>010003364</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/1/90</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>BRAD STODDARD, M.D., VA MEDICAL CENTER, PERRY POINT, MD 21902</b>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Clawson Miller</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>2</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>1345</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>240 52 9690</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>54</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>03-05-36</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Loch Raven VA Medical Center</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  | 9c. COUNTY OF DEATH<br><b>N. CAROLINA</b>   |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |   |  |
| 10a. STATE<br><b>Md</b>   |  | 10b. COUNTY<br><b>N/A</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>2313 NORTH PULASKI STREET</b>  |  |   |  | 10f. ZIP CODE<br><b>21217</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1955-1958</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12th</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>BRICK MASON</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ISAAC MILLER</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MAMIE</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JERALDINE B. THOMAS</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2313 NORTH PULASKI STREET (21217)</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GARRISON FOREST VETERAN</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTO., MARYLAND</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Synette K. Jones</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>BROWN/THOMPSON F.H. P.O. BOX 4433</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  | a. <b>Sepsis</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  | Approximate Interval Between Onset and Death<br><b>1 wk</b>   |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  |  | b. <b>Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  | <b>1 wk</b>   |  |
|   |  | c. <b>Multiple Myeloma</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  | <b>2 mo</b>   |  |
|   |  | d.  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal Failure</b><br><b>Disseminated Intravascular Coagulation</b>   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
|   |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Jeffrey C. Brackett MD</b>  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Jeffrey C. Brackett MD LRVAH</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>4/2 APR 5 - 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Gulie Davidson-Randall</b>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GEORGE JOSEPH MITCHELL</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>APRIL</b> DAY <b>03</b> YEAR <b>1990</b>   |  | 3. TIME OF DEATH<br><b>602 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-03-2147</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>AUG. 21 1909</b>                           |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>NORTH ARUNDEL HOSPITAL</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>GLEN BURNIE</b>   |  | 9c. COUNTY OF DEATH<br><b>ANNE ARUNDEL</b>   |  |
| 10a. STATE<br><b>Maryland</b>  |  |   |  | 10b. COUNTY<br><b>Anne Arundel</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Glen Burnie</b>                                    |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>50 Forestdale Ave.</b>  |  |   |  | 10f. ZIP CODE<br><b>21061</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>           |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b><br>College (13-16) <b>None</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Clothing Cutter</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Max Rubin Cloth</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Peter Mitchell</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rose Bastick</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Anna K. Mitchell</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as 10</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holy Cross Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Brooklyn, Maryland</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SINGLETON FUNERAL HOME<br/>1 SECOND AVE. S.W., GLEN BURNIE, MD 21061</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIO PULMONARY ARREST</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>ACUTE MYOCARDIAL INFARCTION</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Arterio Sclerotic Cardiovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Diabetes Mellitus</b> |  |   |  |   |  |  | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus</b>   |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 29a. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29b. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Attending Doctor</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>021684</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/3/90</b>                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>CHACKUMKAL CYRIAC, M.D. 14 WELHAM AVE., GLEN BURNIE, MARYLAND 21061</b>  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Helen Mary Maurer   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>4 - 3 - 90  |  | 3. TIME OF DEATH<br>8:45 A. M.  |   |
| 4. SOCIAL SECURITY NUMBER<br>217-03-8178  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>70 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>5-15-19  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>SAINT JOSEPH HOSPITAL   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>TOWSON   |  | 9c. COUNTY OF DEATH<br>BALTO.   |   |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |   |   |
| 10a. STATE<br>MD  |  | 10b. COUNTY<br>BALTO.   |  | 10c. CITY, TOWN OR LOCATION<br>BALTO  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>7824 SHEPHERD AVE   |  |   |  | 10f. ZIP CODE<br>21234  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES X  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                                    |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) 12<br>College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Percy C. Pigford   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Anna Mulosky   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Fielding L. Maurer Jr.  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8424 Hallmark Circle Baltimore, Md. 21234  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Moreland Memorial April 6, 1990   |  | 20c. LOCATION — City or Town, State<br>Baltimore, Md.   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>James F. Gladden James F. Gladden  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Leonard J. Ruck Inc. 5305 Harford Rd. 21214   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Intercranial hemorrhage<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. metastatic breast carcinoma<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br>?<br>1 yr.  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY M   |   |
|   |  |   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |   |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Natividad D. de Leon, M.D.   |  |   |  | 29c. LICENSE NUMBER<br>D19508   |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/3/90   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>NATIVIDAD D. DE LEON, C/O ST. JOSEPH HOSPITAL, TOWSON, MD, 21204   |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>APR 5 - 1990   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>[Signature]  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

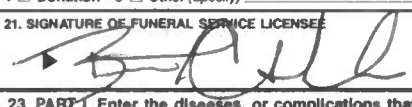
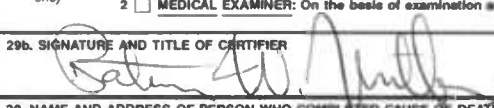

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>AUDRY V. MOUZON   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>4-1-90  |  | 3. TIME OF DEATH<br>10:00 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>234-26-0063  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>70 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>1-6-1920  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>FRANCIS SCOTT KEY MEDICAL CENTER  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE CITY   |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br>MARYLAND  |  | 10b. COUNTY<br>BALTIMORE   |  | 10c. CITY, TOWN OR LOCATION<br>EDGEMERE   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br>2810 WELLS AVENUE   |  |  |  | 10f. ZIP CODE<br>21219  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12TH GRADE   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>HOME MAKER                      |  | 15b. KIND OF BUSINESS/INDUSTRY<br>OWN HOME  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>RAY BUSH   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>MARGARET HANSON  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>WALTER S. MOUZON  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2810 WELLS AVENUE BALTIMORE, MARYLAND 21219  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>BEL AIR MEMORIAL APRIL 5, 1990   |  | 20c. LOCATION — City or Town, State<br>BEL AIR, MARYLAND  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>DUDA-RUCK FUNERAL HOME OF DUNDALK, INC.<br>7922 WISE AVENUE DUNDALK, MD 21222   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Intraventricular hemorrhage</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>HTN</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
|   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br>D37816   |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/1/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Patricia Miller 4940 EASTOWN Avenue F8K  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 5 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>O'Connell, Fabiola</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH <i>4</i> DAY <i>1</i> YEAR <i>90</i>  |  | 3. TIME OF DEATH<br><i>1125 A</i>   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>224-58-1940</i>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><i>95</i> YRS. |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>6/20/94</i> |   | 8. BIRTHPLACE (State or Foreign Country)<br><i>MARYLAND</i>  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>LONG Green Nursing Home</i>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>BALTO. MD</i>   |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br><i>MD.</i>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><i>BALTIMORE CITY</i>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>115 E. MELROSE AVE.</i>  |  |  |  | 10f. ZIP CODE<br><i>21212</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>WHITE</i>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>E</i>                    |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Joseph David Mark</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Margaret Preller</i>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Joseph O'Connell (son)</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>106 W. 56 St., New York, NY 10019</i>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)   |  | 20c. LOCATION — City or Town, State   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Small White</i> <i>4-3-90</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>STATE ANATOMY BOARD, BALTO., MD. 21201</i>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Possible Pneumonia</i><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Multiple decubitus ulcers ASCUD</i><br><i>Dementia, probable multi-infarct</i><br><i>Depression 5/10/84-1985</i>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John P. H. H. H.</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>D 30717</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>4/1/90</i>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Alicia A. Cool-Foley MD 801 E University Pkwy Balto Md 21201</i>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>APR 3 - 1990</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John P. H. H. H.</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1, 2, and 3 should be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

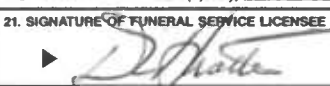
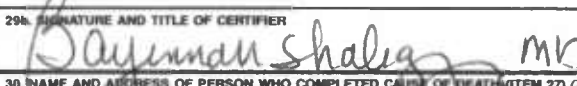
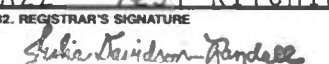
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>ELIZABETH SHIRLEY PETERS   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>APRIL 03 1990   |  | 3. TIME OF DEATH<br>10:30 P M  |  |
| 4. SOCIAL SECURITY NUMBER<br>216-16-2663   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>67 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>OCT. 8 1922   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>North Arundel Hospital   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Glen Burnie  |  | 9c. COUNTY OF DEATH<br>Anne Arundel  |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |  |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Anne Arundel   |  | 10c. CITY, TOWN OR LOCATION<br>Glen Burnie  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br>8065 Green Orchard Rd. Apt. 12   |  |   |  | 10f. ZIP CODE<br>21061  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12th   |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Bookkeeper  |  | 16. KIND OF BUSINESS/INDUSTRY<br>Bank   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Ferdinand Hubbard   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Lucy Boyd  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Robert K. Peters   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Same as 10   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Maryland Veterans Cemetery  |  | 20c. LOCATION — City or Town, State<br>Crownsville, Maryland  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>SINGLETON FUNERAL HOME<br>1 SECOND AVE. S.W., GLEN BURNIE, MD 21061   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiac arrest</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>Diabetes mellitus</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  | Approximate interval Between Onset and Death<br>12 hours   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>End stage renal disease on chronic hemodialysis</u><br><u>Diabetic Neuropathy, retinopathy</u><br><u>Hypertension</u>   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 28a. DATE OF INJURY (Month, Day, Year)<br>N/A   |  | 28b. TIME OF INJURY<br>N/A   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED<br>N/A  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>N/A   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>N/A  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br> MD  |  |   |  | 29c. LICENSE NUMBER<br>024592   |  | 29d. DATE SIGNED (Month, Day, Year)<br>5 April 90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DR. BAYINNA SHABAZZ 7231 RITCHIE HIGHWAY GLEN BURNIE MARYLAND   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 5 - 1990  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |  |  |  |
|--|--|--|--|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARY G POLTORAK</b>   |  |  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APR 1 91 1990</b>                   |  | 3. TIME OF DEATH<br><b>7:20 A M</b>   |  |   |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>141-38-2347</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug. 26, 1905</b>                  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>CONN.</b>  |  |   |  |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>BROOKE GROVE NURSING HOME</b>   |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>OLNEY</b>                          |  |   |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |  |   |  |  |  |
| 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>MONTGOMERY</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>WHEATON</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |   |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>2932 BEAVERWOOD LANE</b>  |  |  |  |  |  | 10f. ZIP CODE<br><b>20906</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |   |  |   |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>                                |  |   |  |   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>STEPHEN DOLINSKI</b>   |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY FETZMAN</b>     |  |   |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>STEPHEN POLTORAK</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11670 -303 LITTLE PATUXENT PKWY. COLUMBIA, MD. 21044</b>   |  |  |  |   |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>METROPOLITAN CREMATORY</b>  |  |  |  | 20c. LOCATION — City or Town, State<br><b>ALEXANDRIA, VA.</b>                                   |  |   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MURIEL H. BARBER FUNERAL HOME</b><br><b>21525 LAYTONSVILLE ROAD LAYTONSVILLE, MD. 20882</b>   |  |  |  |   |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ASPIRATION PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>ADVANCED ALZHEIMER'S DEMENTIA</b> |  |  |  |  |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ADVANCED ALZHEIMER'S DEMENTIA</b>   |  |  |  |  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |   |  |   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  | 29c. LICENSE NUMBER<br><b>D33700</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-1-90</b> |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>TED E. HOWE, MD</b><br><b>OLNEY, MD</b>  |  |  |  |  |  |  |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 - 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |   |  |   |  |   |  |  |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Charles Henry Poulton</b>  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>30</b> YEAR <b>1990</b>  |  | 3. TIME OF DEATH<br><b>10 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-07-7164</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.   |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>05-31-17</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>1312 Poplar Avenue 21227</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Arbutus</b>  |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Arbutus</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>1312 Poplar Avenue</b>  |  | 10f. ZIP CODE<br><b>21227</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Letter Carrier</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Postal Service</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Pembroke Thom Poulton</b>   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Anna Seipe</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Grace P. Bensen</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1739 Edgewood Road, Baltimore, MD 21234</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Greenlawn Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Cambridge, MD</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>George E. MacNabb</b>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MacNabb Funeral Home<br/>301 Frederick Road, Catonsville, MD</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic Cardiovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d.</b> |  |  |  |  | Approximate Interval Between Onset and Death<br><b>Autopsy</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
|   |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
|   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Deputy Medical Examiner</b>   |  | 29c. LICENSE NUMBER<br><b>001080</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>March 30, 1990</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Strick, 3 - Fe/senbers MD 11 E. Chase St RA 21202</b>   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 - 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>John H. ...</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br>MARIAN Rodwell.  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>4 1 90  |  | 3. TIME OF DEATH<br>9:00 A M  |  |
| 4. SOCIAL SECURITY NUMBER<br>215-30-4624   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>56 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>1 24 1934  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>THE JOHNS HOPKINS HOSPITAL   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |  | 9c. COUNTY OF DEATH<br>BALTIMORE CITY   |  |
| RESIDENCE OF DECEASED  |  |  |  |   |  |   |  |
| 10a. STATE<br>MARYLAND   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br>4407 Belle Ave   |  |  |  | 10f. ZIP CODE<br>21207  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK  |  |
| 15. DECEASED'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)   |  | 16a. DECEASED'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Teacher   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Cherity Elizabeth Pass   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Archer L. Rodwell  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4407 Belle Ave BALTIMORE, Maryland 21207   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>GARISON FOREST   |  | 20c. LOCATION — City or Town, State<br>Owings Mill, Md  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Wm Brown  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>William C. Brown Community FH 206 W. North  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. CARDIAC ARREST<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  | Approximate Interval Between Onset and Death<br>2-3 MINUTES   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  | b. HEPATIC FAILURE<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  | 3 mos.  |  |
|  |  | c. METASTATIC COLON CANCER<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  | 18 mos.   |  |
|  |  | d.   |  |   |  |   |  |
|  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation<br>a <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>John H. Fetting   |  |  |  | 29c. LICENSE NUMBER<br>A18320   |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/1/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>John H. Fetting M.D. Johns Hopkins Oncology Center Baltimore MD 21205   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 5 - 1990  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be required by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Green, Eric Randolph</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>2</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>7:15 PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-88-1685</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>26</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>7/28/63</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>UNIVERSITY HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br><b>MARYLAND</b>   |  |  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>2415 BARNESLEY PLACE</b>   |  |  |  | 10f. ZIP CODE<br><b>21207</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (8-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)                                       |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>WALTER LEE GREEN</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>HELEN BECK</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>HELEN GREEN</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2415 BARNESLEY PLACE: BALTO., MD. 21207</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GUILFORD CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>COLUMBIA, MARYLAND</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Leroy O. Dyett</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROY O. DYETT &amp; SON FUNERAL HOME<br/>4600 LIBERTY HEIGHTS AVENUE</b>  |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Mycobacterium Avium Intracellulare</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>AIDS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>1 year</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dysphagia, Malnutrition, anemia</b>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  | 25b. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J. Bogart MD</i>  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/2/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J. Bogart MD - Univ of MD Hospital</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>THOMAS EDWARD SOKOLOSKI  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>APRIL 3 1990  |  | 3. TIME OF DEATH<br>10:14 P. M.  |  |
| 4. SOCIAL SECURITY NUMBER<br>196-03-0902   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>73 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>DEC. 21 1916                                  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Pennsylvania   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Mercy Hospital  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore                                     |  |
| 9c. COUNTY OF DEATH<br>Baltimore City  |  |  |  | 10a. STATE<br>Maryland  |  |  |  |
| 10b. COUNTY<br>Anne Arundel  |  | 10c. CITY, TOWN OR LOCATION<br>Hanover   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |
| 10e. STREET AND NUMBER<br>7426 Randolph Court  |  |  |  | 10f. ZIP CODE<br>21076  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>W.W.II   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>UNKNOWN  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Longshoreman   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Shipping  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>(UNKNOWN)   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>(UNKNOWN)  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>John M. Valunas  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2947 Edgewood Ave., Baltimore, Maryland 21234  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Glen Haven Memorial Park   |  | 20c. LOCATION — City or Town, State<br>Glen Burnie, Maryland  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>SINGLETON FUNERAL HOME<br>1 SECOND AVE. S.W., GLEN BURNIE, MD 21061   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <i>Interarterial Cardiac Vascular Disease</i> years   |  |   |  |  |  |
|  |  | b. <i>Cerebral Artery Disease Seven</i> years  |  |   |  |  |  |
|  |  | c. _____   |  |   |  |  |  |
|  |  | d. _____   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Rolando V. Gocum</i>   |  | 29c. LICENSE NUMBER<br>P01860   |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/4/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Rolando V. Gocum 707 E. Fort Ave Balt. Md 21230   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 5 - 1990  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Maurice Rogers</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-2-90</b>   |  | 3. TIME OF DEATH<br><b>1:32PM</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-64-0195</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><b>35</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>8/1/54</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>5300 Ethelbert Avenue (RES.)</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 9c. COUNTY OF DEATH<br><b>MARYLAND</b>  |  |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10a. STREET AND NUMBER<br><b>5300 ETHELBERT AVENUE</b>  |  |  |  | 10i. ZIP CODE<br><b>21215</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>                          |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 18a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)  |  | 18b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHN E. ROGERS</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>SANNIE HAMILTON</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JOHN E. ROGERS</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5300 ETHELBERT AVE. BALTO., MD. 21215</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>WESTERN STAR CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>CATONSVILLE, MD.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Leroy O. Dyett</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROY O. DYETT &amp; SON FUNERAL HOME<br/>4600 LIBERTY HEIGHTS AVENUE</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Fatty and fibrotic liver</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Chronic alcoholism</b><br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Margaret A. Korell</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>OCME</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-3-90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARGARITA A. KORELL, MD 111 Penn Street, Baltimore, MD 21201</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Lisa Trudman Randall</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

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2011 09



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Veronica Lynn Rush Stevenson   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3-28-90   |  | 3. TIME OF DEATH<br>12:24PM M  |  |
| 4. SOCIAL SECURITY NUMBER<br>217-82-5833   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>27 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Feb. 9, 1963  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Johns Hopkins Hospital   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br>Maryland   |  |  |  | 10b. COUNTY<br>Prince George's  |  | 10c. CITY, TOWN OR LOCATION<br>Landover Hills  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>5114-Flintridge Drive  |  |  |  | 10f. ZIP CODE<br>20784  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) 11<br>College (1-4 or 5+) 11   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Teaching assistant              |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Public Schools  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Johnnie R. Rush   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Edith Veronica Stephenson  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Edith V. Frazier (Mother)  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5114-Flintridge Drive, Landover Hills, MD 20784  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Lee's Crematory  |  | 20c. LOCATION — City or Town, State<br>Washington, D.C.   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Charles L. Belanger   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>J. William Lee's Sons Company Funeral Home<br>300-4th St., NE, Washington, D.C. 20002-5816  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused this death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acquired Immune Deficiency Syndrome with complications<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  | Approximate interval Between Onset and Death<br>XXX  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>INQUIRY   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Julia C. Goodin, MD   |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-29-90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>JULIA C. GOODIN, MD 111 Penn Street, Baltimore, MD 21201  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 5 - 1990  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Goodin-Randell  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 08748

1 - FOR STATE REGISTRAR ERNEST H. STROUSE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH REG. NO.

|   |  |  |  |   |   |
|---|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ERNEST H STROUSE</b>   |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>1</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>3:35 P.M.</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>215-34-8553</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>52</b> YRS.  |   |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>8-6-37</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MD.</b>   |  |   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Montgomery General Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Olin</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |   |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Ashton</b>  |   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>209 Ashlawn Drive</b>   |  | 10f. ZIP CODE<br><b>20861</b>   |   |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1961-1966</b> |   |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b><br>College (1-4 or 5+) <b>-</b>                            |   |
| 16. KIND OF BUSINESS/INDUSTRY<br><b>MASONRY</b>   |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>ERNEST H. STROUSE</b>  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY WHITEHEAD</b>  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>PHYLLIS A. STROUSE</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>SAME AS #10</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>BURTONSVILLE UNION</b>  |  | 20c. LOCATION — City or Town, State<br><b>BURTONSVILLE, MD.</b>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Muriel H. Barber</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MURIEL H. BARBER FUNERAL HOME</b><br><b>21525 LAYTONSVILLE RD. LAYTONSVILLE, MD. 20882</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Myocardial Infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   | Approximate Interval Between Onset and Death<br><b>minutes</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes mellitus</b>  |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>N/A</b>   |  | 28b. TIME OF INJURY<br><b>M</b>   |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Paul A. Severe</i><br><b>Deputy Medical Examiner</b>  |  | 29c. LICENSE NUMBER<br><b>201862</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/1/90</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Paul A. Severe MD Deputy Medical Examiner</b><br><b>4203 Queensbury Rd Hyattsville MD 20781</b>   |  |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is devoted to a general description of the project and its objectives. It is followed by a brief review of the literature on the subject.

2. The second part of the report describes the methodology used in the study. This includes a detailed account of the data collection process and the statistical methods employed for data analysis.

3. The third part of the report presents the results of the study. These are discussed in the context of the research objectives and the existing literature.

4. The fourth part of the report discusses the implications of the findings and suggests areas for further research. It also includes a conclusion and a list of references.

5. The fifth part of the report is a summary of the main findings and conclusions. It is followed by a list of references and an appendix containing additional data and figures.

6. The sixth part of the report is a detailed discussion of the results. It includes a comparison of the findings with those of other studies and a discussion of the limitations of the study.

7. The seventh part of the report is a summary of the main findings and conclusions. It is followed by a list of references and an appendix containing additional data and figures.

8. The eighth part of the report is a detailed discussion of the results. It includes a comparison of the findings with those of other studies and a discussion of the limitations of the study.

9. The ninth part of the report is a summary of the main findings and conclusions. It is followed by a list of references and an appendix containing additional data and figures.

10. The tenth part of the report is a detailed discussion of the results. It includes a comparison of the findings with those of other studies and a discussion of the limitations of the study.

11. The eleventh part of the report is a summary of the main findings and conclusions. It is followed by a list of references and an appendix containing additional data and figures.

12. The twelfth part of the report is a detailed discussion of the results. It includes a comparison of the findings with those of other studies and a discussion of the limitations of the study.

90 08749

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>TIMOTHY LEE SWAIM</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 2 1990</b>   |  | 3. TIME OF DEATH<br>HOURS MINUTES<br><b>4:35 A M</b>                                 |   |
| 4. SOCIAL SECURITY NUMBER<br><b>238-57-7405</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>17</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>OCT 7 1972</b>                          |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>NATIONAL NAVAL MEDICAL CENTER</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BETHESDA</b>  |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |   |
| 10a. STATE<br><b>NORTH CAROLINA</b>   |  |  |  | 10b. COUNTY<br><b>ONslow</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>JACKSONVILLE</b>                                   |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |   |
| 10e. STREET AND NUMBER<br><b>316 SPRING DRIVE</b>   |  |  |  | 10f. ZIP CODE<br><b>28540</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>                                |   |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>           |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b><br>College (1-4 or 5+) <b>11</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>STUDENT</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>HIGH SCHOOL</b>  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>VERNON DOYLE SWAIM</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CAROLYN ANN MELTON</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CAROLYN A. SWAIM</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>316 SPRING DRIVE, JACKSONVILLE, NC 28540</b>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Onslow Memorial Park</b>  |  | 20c. LOCATION — City or Town, State<br><b>Jacksonville, NC</b>  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>David J. Lawrence</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Capitol Funeral Service<br/>Falls Church, VA</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ACUTE LYMPHOCYTIC LEUKEMIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
|   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>D.B. Robinson MD.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D-37337</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>APR 2 1990</b>                             |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>D. B. ROBINSON, LCDR, MC, USNR</b><br><b>NATIONAL NAVAL MEDICAL CENTER</b><br><b>BETHESDA, MD 20814-5011</b>  |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNITED STATES OF AMERICA  
DO hereby certify that  
the within and foregoing is a true and correct  
copy of the original as the same appears  
in the records of the Department of the Interior.

66 Capin  
90 087501 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ETHEL R. SINGER</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>04-03-90</b>   |  | 3. TIME OF DEATH<br><b>6:15 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-03-5924</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>86</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>7/8/1903</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Harbor Hospital Center</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Balto. City, Md.</b>  |  |
| 9c. COUNTY OF DEATH<br><b>-----</b>  |  |  |  | 10a. STATE<br><b>Md.</b>  |  | 10b. COUNTY<br><b>-----</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Balto. City, Md.</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>600 Light St.</b>  |  |
| 10f. ZIP CODE<br><b>21230</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th. Grade</b><br>College (1-4 or 5+) <b>-----</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Dress Maker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>I.L.G.W.U.</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Henry --- Hesselbacher</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lucinda --- Bonsal</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. E. Nelson King</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1615 Turtle Creek, Missouri City, Tex. 77459</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gardens of Faith Cemt.</b>   |  | 20c. LOCATION — City or Town, State<br><b>Md. Rossville, Balto. Co.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Daniel A. Taylor</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Balto. Md. 21230<br/>McCully Funeral Home. 130 E. Fort Ave.</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Breast CA, Left</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>unknown</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)   |  |  |  |   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined |  |
| 28a. DATE OF INJURY (Month, Day, Year)<br><b>NA</b>  |  |  |  |   |  | 28b. TIME OF INJURY<br><b>NA M</b>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>NA</b>  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>NA</b>  |  |  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>NA</b>   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Priscilla E. Jin MD - Med. Resident</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 39199</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-3-90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>GRISelda E. Tiu, MD 3001 S. HANOVER ST. BALTIMORE MD 21201</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 - 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as a death certificate permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

1 - FOR  
STATE  
REGISTER

**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

REG. NO.

90 08751

|  |  |   |   |   |  |  |   |   |  |   |  |
|--|--|---|---|---|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Shackelford Virginia Shackelford</i>  |  | 2. DATE OF DEATH<br>MONTH <i>3</i> DAY <i>30</i> YEAR <i>90</i>   |   | 3. TIME OF DEATH<br><i>12:30 A M</i>  |  |  |   |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>579-09-1967</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 6. AGE (In yrs. last birthday)<br><i>81</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>09-23-1908</i>                      |   | 8. BIRTHPLACE (State or Foreign Country)<br><i>Virginia</i>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>St. Agnes Hospital</i>  |  |   |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore</i>   |  |  |   | 9c. COUNTY OF DEATH<br><i>---</i>   |  |   |  |
| RESIDENCE OF DECEDENT  |  |   |   |   |  |  |   |   |  |   |  |
| 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Prince Georges</i>  |   | 10c. CITY, TOWN OR LOCATION<br><i>Laurel</i>  |  |  |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br><i>109 Brashears Street</i>  |  |   |   | 10f. ZIP CODE<br><i>20707</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                      |   |   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i> |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>7th</i> College (1-4 or 5+) <i>---</i>  |  |   | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Homemaker</i> |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Home</i>                                    |   |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>David Henry Shobe</i>  |  |   |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Elizabeth Hawse</i>   |  |  |   |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Susan Austin</i>  |  |   |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>600 Walker Ave. Apt C, Balto., MD 21212</i>   |  |  |   |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Metro Crematory, Inc.</i>  |   |   |  | 20c. LOCATION — City or Town, State<br><i>Baltimore, MD</i>                      |   |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>George E. MacNabb</i>  |  |   |   | 22. NAME AND ADDRESS OF FACILITY<br><i>Cremation Society of Maryland<br/>Baltimore, MD 21228</i>  |  |  |   |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Aspiration pneumonia</i><br><br>Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |   |   |   |  |  |   | Approximate Interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>UTI</i>   |  |   |   |   |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |   |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |   | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER<br>(Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Y. MONICA MD</i>  |   |   |  | 29c. LICENSE NUMBER  |   | 29d. DATE SIGNED (Month, Day, Year)<br><i>3/30/90</i>   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>St Agnes Hosp. 900 CATON AVE</i>   |  |   |   |   |  |  |   |   |  |   |  |
| 31. DATE FILED (Month/Day, Year)<br><i>APR 5 - 1990</i>  |  |   |   | 32. REGISTRAR'S SIGNATURE<br><i>Gina Davidson-Randall</i>   |  |  |   |   |  |   |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>EMMA SHAW  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>4-3-1990  |  | 3. TIME OF DEATH<br>1:05 A.M. M  |  |
| 4. SOCIAL SECURITY NUMBER<br>406-20-6290   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>85 YRS.  |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br>6-9-1904   |  | 8. BIRTHPLACE (State or Foreign Country)<br>Ky.   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Meridian Cromwell Nursing Home   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Towson   |  | 9c. COUNTY OF DEATH<br>Baltimore   |  |
| 10a. STATE<br>Ky.  |  | 10b. COUNTY<br>Bourbon  |  | 10c. CITY, TOWN OR LOCATION<br>Paris   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>720 Vine Street   |  | 10f. ZIP CODE<br>40361   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White   |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) 12 Yrs.<br>College (1-4 or 5+)                 |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  | 17. FATHER'S NAME (First, Middle, Last)<br>Nick Westfall   |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Kate Barton   |  | 19a. INFORMANT'S NAME (Type/Print)<br>Nathan C. Shaw, Jr.   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5313 Grindon Ave., Balto., Md. 21214            |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Carlisle Cemetery 4-5-90  |  | 20c. LOCATION — City or Town, State<br>Carlisle, Ky.   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Roy H. Cather<br><i>Roy H. Cather</i>   |  | 22. NAME AND ADDRESS OF FACILITY<br>Leonard J. Ruck, Inc., 5305 Harford Rd., Balto., Md. 21214  |  |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pneumonia</i><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <i>Prior Stroke</i><br>c.<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Urinary Tract Infection</i><br><i>Sepsis</i> |  |   |  |  | Approximate Interval Between Onset and Death |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br>N/A  |  | 28b. TIME OF INJURY<br>N/A   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br>N/A  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>N/A  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>N/A  |  | 29a. CERTIFIER (Check only)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John T. Evelius MD</i>   |  | 29c. LICENSE NUMBER<br>D34952   |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/3/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. John Thomas Evelius, M.D., 5444 Belair Rd., Balto., Md. 21206   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 5 - 1990  |  | 32. REGISTRAR'S SIGNATURE<br><i>Sasha Davidson-Rendell</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |   |
|--|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DEKEYA TARIA TAYLOR</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>1</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>M</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>213-98-5289</b>  |  | 5. SEX<br><b>1</b> M <b>2</b> F  |  | 6. AGE (In yrs. last birthday)<br><b>9</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11-25-80</b>  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MD</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>2306 EAST NORTH AVENUE</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |   |
| 9c. COUNTY OF DEATH  |  |  |  | 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY   |   |
| 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> YES <b>2</b> NO   |  | 10e. STREET AND NUMBER<br><b>1307 EAST NORTH AVENUE</b>   |   |
| 10f. ZIP CODE<br><b>21213</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> YES <b>2</b> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                             |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Child</b> College (1-4 or 5+) <b>Child</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Child</b>                           |  | 16b. KIND OF BUSINESS/INDUSTRY  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>HORRACE BURNETT</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>DONZELLA BAILEY</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>DONZELLA BAILEY</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1307 EAST NORTH AVE./BALTIMORE, MD 21213</b>     |  |   |   |
| 20a. METHOD OF DISPOSITION<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>BALTIMORE CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD</b>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Wladimir Wanner</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM. C. MARCH F.H. 1101 E. NORTH AVE.</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Neuroblastoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> |  |  |  |  |  |   | Approximate Interval Between Onset and Death<br><b>13 mos</b> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> YES <b>2</b> NO    |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> YES <b>2</b> NO  |  |  |  |  |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> YES <b>2</b> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA OTHER: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |  |  |   |   |
| 27. MANNER OF DEATH<br><b>1</b> Natural <b>5</b> Pending Investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><b>1</b> YES <b>2</b> NO  |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |
| 29a. CERTIFIER (Check only one)<br><b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Bonnie L. Hales MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D19138</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/2/90</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Brian G. Leventhal MD, CUSC 800, Johns Hopkins Hospital</b>  |  |  |  |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ANNIE P. VERMILLION</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 26, 1990</b>  |  | 3. TIME OF DEATH<br><b>4:25 P. M.</b>  |  |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>9/29/09</b>   | 8. BIRTHPLACE (State or Foreign Country) |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Mary's Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Leonardtwn</b>   |  | 9c. COUNTY OF DEATH<br><b>St. Mary's</b>   |  |  |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |  |  |  |
| 10a. STATE<br><b>MD.</b>  |  | 10b. COUNTY<br><b>ST. MARYS</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>LEXINGTON PARK</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |
| 10e. STREET AND NUMBER<br><b>1500 GREAT MILLS RD.</b>   |  |  |  | 10f. ZIP CODE  |  | 10g. CITIZEN OF WHAT COUNTRY?  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>               |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do not use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>In-state removal</b>  |  | 20c. LOCATION — City or Town, State  |  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i> <b>4-3-90</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>STATE ANATOMY BOARD, BALTO., MD. 21201</b>  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acute Aspiration Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Acute Pyelonephritis, Diabetes Mellitus</b> |  |  |  |  |  |  | Approximate Interval Between Onset and Death |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO     |  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> <b>Ms</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D19917</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/27/90</b>                                    |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>James C. Boyd, M.D. Leonardtown, Md. 20650</b>  |  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Clarence H. Williams   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March 29, 1990  |  | 3. TIME OF DEATH<br>3:05PM M  |  |
| 4. SOCIAL SECURITY NUMBER<br>218-18-8996   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>83 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>27-Mar-07  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Md.  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Maryland General Hospital   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |  |
| 9c. COUNTY OF DEATH  |  |  |  |   |  |   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br>Md.  |  | 10b. COUNTY<br>USA   |  | 10c. CITY, TOWN OR LOCATION<br>Balto. Md.   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>1405 Madison ave   |  | 10f. ZIP CODE<br>21217   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES       |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Negro                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (14 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Secretary-Ret                         |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Fun. Home   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Hyland Williams   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Laura Lightfoot  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mildred A. Williams  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1405 Madison Ave - 21217   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Balto. Nat'l. Cemetery   |  | 20c. LOCATION — City or Town, State<br>Balto. Md.   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Charles H. Powell   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>1206 W North Ave (17)   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | Intra ventricular hemorrhage   |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | a. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | b. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | HOSPITAL:<br>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA                   |  | OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|  |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>A. ADADA M.D.   |  |  |  | 29c. LICENSE NUMBER<br>n/a  |  | 29d. DATE SIGNED (Month, Day, Year)<br>3/29/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Anisa Adada, M.D. c/o Maryland General Hospital   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 5 - 1990  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

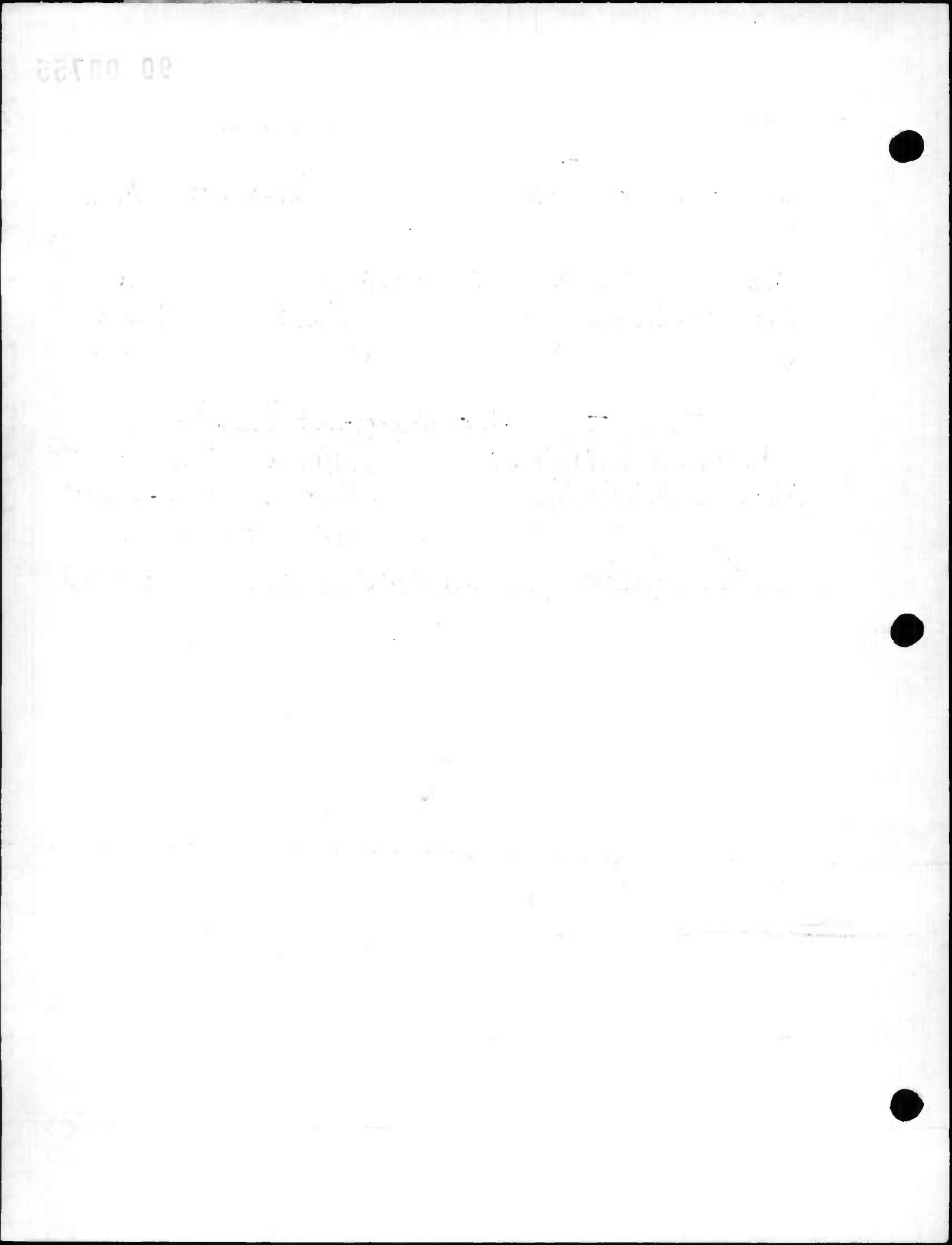
BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>William R. Walker</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>30</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>5:00 PM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-30-6098</b>  |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>55</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11/18/35</b>   |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>VA LOCHRANS</b>   |  |   |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore, Maryland</b>  |  | 8c. COUNTY OF DEATH<br><b>MD</b>   |  |
| 10a. STATE<br><b>MD</b>  |  |   |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  |
| 10d. INSIDE CITY LIMITS<br><b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br><b>337 E 22nd St.</b>  |  | 10f. ZIP CODE<br><b>21213</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  | 11. MARITAL STATUS<br><b>3</b> <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>NA</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Custodian</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Social Security</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James Walker</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Nazareth Richardson</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Doletta Johnson</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2309 Druid Hill Ave. Balt. MD. 21217</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cem.</b>   |  | 20c. LOCATION — City or Town, State<br><b>Anne Arundel Co. MD</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Calvin L. Williams</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Wm. C. March Funeral Home<br/>1101 E. North Avenue 21201</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>a. Squamous Cell Carcinoma of Tongue, throat</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Neck Cancer, Pharyngeal Cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b> |  |   |  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Respiratory insufficiency</b>   |  |   |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Respiratory insufficiency</b>   |  |   |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                           |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  | 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Bramon A. Biot MD</b>  |  |   |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/30/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>22 South Greene St Balt. MD 21201</b>  |  |   |  |  |  |  |  |
| 31. DATE FILLED (Month, Day, Year)   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>APR 5 1990 John F. [Signature]</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

80 00755

1987 100 00755

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>John Jessie White</i>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>3-25-90</i>  |  | 3. TIME OF DEATH<br>HOUR MIN. SEC.<br><i>8 A M</i>                |  |
| 4. SOCIAL SECURITY NUMBER<br><i>250-26-0593</i>   |  | 5. SEX<br><i>1 M 2 F</i>  | 6. AGE (In yrs. last birthday)<br><i>67</i> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><i>March 21, 1923</i>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><i>South Carolina</i> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>1215 Adeline Way</i>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Capitol Heights</i>   |  | 9c. COUNTY OF DEATH<br><i>Prince George's</i>                     |  |
| 10a. STATE<br><i>Maryland</i>   |  |   |  | 10b. COUNTY<br><i>Prince George's</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>Capitol Heights</i>             |  |
| 10d. INSIDE CITY LIMITS?<br><i>1 YES 2 NO</i>   |  |   |  | 10e. STREET AND NUMBER<br><i>1215 Adeline Way</i>   |  |   |  |
| 10f. ZIP CODE<br><i>20743</i>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>   |  |   |  |
| 11. MARITAL STATUS<br><i>1 NEVER MARRIED 2 MARRIED 3 WIDOWED 4 DIVORCED</i>   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><i>1 YES 2 NO</i>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><i>1 YES 2 NO</i>                 |  | 14. RACE — American Indian, Black, White, etc.<br><i>Black</i>    |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><i>8th Grade</i>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Painter</i>                      |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Private</i>                  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Kibb White</i>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Viola Owens</i>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Jane White</i>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1215 Adeline Way, Capitol Hgts., Maryland</i> |  |   |  |
| 20a. METHOD OF DISPOSITION<br><i>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</i>   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Lee's Crematorium</i>  |  | 20c. LOCATION — City or Town, State<br><i>Washington, D.C.</i>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John T. Stewart, III</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Stewart Funeral Home<br/>4001 Benning Road, N.E. Wash. D.C.</i>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Interoperative cardiovascular disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>  |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><i>1 YES 2 NO</i>   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><i>1 YES 2 NO</i>  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><i>1 YES 2 NO</i>   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <i>1 Inpatient 2 ER/Outpatient 3 DOA</i><br>OTHER: <i>4 Nursing Home 5 Residence 6 Other (Specify)</i> |  |   |  |   |  |
| 27. MANNER OF DEATH<br><i>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</i>   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><i>1 YES 2 NO</i>                         |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><i>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i><br><i>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i>   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Augusto P. Rodriguez, M.D.</i>  |  |   |  | 29c. LICENSE NUMBER<br><i>D21230</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>3-25-90</i>             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Augusto P. Rodriguez, M.D. 5009 Rayburn Ct., Camp Springs, MD 20748</i>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>APR 5 1990</i>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Shera Anderson-Randall</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

50 00127

III

90 08758

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Arthur L. Wilson</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>31</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>0209 A.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-56-5415</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS.   |  | 7. DATE OF BIRTH<br>MONTH <b>2</b> DAY <b>15</b> YEAR <b>27</b>                                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Agnes Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>900 S. Caton Ave.</b>  |  | 9c. COUNTY OF DEATH<br><b>Baltimore City</b>  |  |
| 10a. STATE<br><b>Md.</b>  |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>900 S. Beechfield Ave.</b>   |  |  |  | 10f. ZIP CODE<br><b>21229</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>St. Agnes Hospital</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>900 S. Caton Ave. Baltimore, Md. 21229</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <b>in-state removal</b>   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)   |  | 20c. LOCATION — City or Town, State  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>STATE ANATOMY BOARD, BALTO., MD. 21201</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIAC ARREST</b><br><br>Due TO (OR AS A CONSEQUENCE OF):<br><b>LYMPHOMA</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>LYMPHOMA</b><br>Due TO (OR AS A CONSEQUENCE OF):<br>b.<br>Due TO (OR AS A CONSEQUENCE OF):<br>c.<br>Due TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |   |  |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D19419</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/31/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DIANA A. CRITCHFIELD MD 900 CATON AVE. BALTO. MD</b>  |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 3 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR  
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH  
REG. NO.

90 08759

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mary F. Williams</b>  |  | 2. DATE OF DEATH<br>MONTH <b>03</b> DAY <b>29</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>10:45 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-14-5252</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.   |  |
| 7. DATE OF BIRTH (Month, Day, Year)<br><b>04-25-15</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>  |  | 9. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>BON SECOURS HOSPITAL</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  | 9c. COUNTY OF DEATH<br><b>N/A</b>  |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>N/A</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>527 NORTH CALHOUN STREET</b>  |  | 10f. ZIP CODE<br><b>21223</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHN ERNEST CURTIS</b>   |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY E. SMITH</b>  |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>ALBERT WILLIAMS</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>527 NORTH CALHOUN STREET (21223)</b>   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CROWNSVILLE VETERAN CEM.</b>  |  | 20c. LOCATION — City or Town, State<br><b>CROWNSVILLE, MD.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Shirlette K. Jones</b>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>BROWN/THOMPSON F.H. P.O. BOX 4433</b>   |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Myocardial Infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF): <b>CVA</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a.<br>b.<br>c.<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Adnan Sunji M.D.</b>   |  | 29c. LICENSE NUMBER<br><b>D 38962</b>  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>3/29/90</b>  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ADNAN A. SUNJI M.D. - Bon Secours Hospital</b>   |  | 31. DATE FILED (Month, Day, Year)<br><b>APR 5 - 1990</b>   |  |
| 32. REGISTRAR'S SIGNATURE<br><b>J. Davidson</b>  |  |  |  |  |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LAURA MARGARET WALKER</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 3 1990</b>   |  | 3. TIME OF DEATH<br><b>5:20 P.M.</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>081-10-3905</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>95</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MAY 23 1894</b>   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Crofton Convalescent Center</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Crofton</b>   |  | 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>  |   |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Anne Arundel</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Glen Burnie</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>7888 Tall Pines Court</b>  |  |  |  | 10f. ZIP CODE<br><b>21061</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4 or 5+) <b>None</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Boyne</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Frances Scutt</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>John Walker</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>502 Baylor Road, Glen Burnie, Md. 21061</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Glen Haven Memorial Park</b>  |  | 20c. LOCATION — City or Town, State<br><b>Glen Burnie, Maryland</b>   |  |   |   |
| 21. SIGNATURE OF REGISTRAR<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SINGLETON FUNERAL HOME<br/>1 SECOND AVE. S.W., GLEN BURNIE, MD 21061</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>RESPIRATORY FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>2 DAYS</b><br><b>YEARS</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____<br>_____  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|   |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |   |
|   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br><b>B23454</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/4/90</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>BARRY R. NATHANSON MD, 51 FRANKLIN ST. ANNAPOLIS, MD 21401</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 5 - 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |   |
|---|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Myron E. Wood</u> MYRON E. WOOD  |  |  |  | 2. DATE OF DEATH<br>MONTH <u>4</u> DAY <u>2</u> YEAR <u>90</u>   |  | 3. TIME OF DEATH<br><u>4:45</u> / <u>PM</u>                             |   |
| 4. SOCIAL SECURITY NUMBER<br><u>212-03-2514</u>   |  | 5. SEX<br><u>1</u> M <u>2</u> F  | 6. AGE (In yrs. last birthday)<br><u>81</u> YRS. | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____   | IF UNDER 24 HRS.<br>HOURS _____ MIN. _____ | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>12-28-08</u>               |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><u>OKLAHOMA</u>   |  |  |  | 9. COUNTY OF DEATH<br><u>BALTIMORE</u>   |  |   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><u>St. Joseph Hospital</u>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Towson, Md 21204</u>   |  | 9c. COUNTY OF DEATH<br><u>BALTIMORE</u>                                 |   |
| 10a. STATE<br><u>MARYLAND</u>   |  |  |  | 10b. COUNTY<br><u>BALTIMORE</u>  |  | 10c. CITY, TOWN OR LOCATION<br><u>BALTIMORE</u>                         |   |
| 10d. INSIDE CITY LIMITS?<br><u>1</u> YES <u>2</u> NO  |  |  |  | 10e. STREET AND NUMBER<br><u>2618 EVERGREEN AVE.</u>   |  |   |   |
| 10f. ZIP CODE<br><u>21214</u>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |   |   |
| 11. MARITAL STATUS<br><u>2</u> Married<br>1 <input type="checkbox"/> Never Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><u>1</u> YES <u>2</u> NO<br>IF YES, GIVE WAR OR DATES<br><u>WW II</u>                         |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><u>1</u> YES <u>2</u> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <u>WHITE</u> |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>4</u>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>SELF EMPLOYED- OWNER</u> |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>SERVICE STATION</u>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>ALBERT WOOD</u>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>ETHEL RECTOR</u>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>HESTER WOOD</u>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>2618 EVERGREEN AVE. BALTIMORE MD. 21214</u>      |  |   |   |
| 20a. METHOD OF DISPOSITION<br><u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>DRUID RIDGE 4/5/90</u>  |  | 20c. LOCATION — City or Town, State<br><u>BALTIMORE MARYLAND</u>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Dennis Capitano</u>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>BALTIMORE MD. 21214</u><br><u>LEONARD J. RUCK INC. 5305 HARFORD RD.</u>                                       |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. Dissecting Aortic Aneurysm</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. _____ DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____ DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |  |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>COPD</u>   |  |  |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><u>1</u> YES <u>2</u> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><u>1</u> YES <u>2</u> NO  |  |  |  |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><u>1</u> YES <u>2</u> NO |
| 27. MANNER OF DEATH<br><u>1</u> Natural <u>5</u> Pending Investigation<br><u>2</u> Accident <u>3</u> Suicide <u>4</u> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><u>4/2/90</u>  |  | 28b. TIME OF INJURY<br><u>M</u>  |  | 28c. INJURY AT WORK?<br><u>1</u> YES <u>2</u> NO                        |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |
| 29a. CERTIFIER (Check only one)<br><u>1</u> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><u>2</u> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |   | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>[Signature]</u>   |
| 29c. LICENSE NUMBER   |  |  |  |  |  |   | 29d. DATE SIGNED (Month, Day, Year)<br><u>4/2/90</u>  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>MARK STANISLAW 110 S. 2nd Ave. Rm.</u>  |  |  |  |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><u>APR 5 - 1990</u>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>Edward J. Allen Jr.</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 4 1990</b>  |  | 3. TIME OF DEATH<br><b>0015 AM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-20-6907</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>61</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2-12-1928</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>PENINSULA GENERAL HOSPITAL</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SALISBURY, MARYLAND</b>  |  |
| 9c. COUNTY OF DEATH<br><b>WICOMICO</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Worcester</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Snowhill</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>437 W. Market Street</b>  |  |
| 10f. ZIP CODE<br><b>21863</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Laborer</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>None</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Edward J. Allen Sr.</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rosa Stevenson</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Sylvester Dale</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>204 S. Ross St. Snowhill Md. 21863</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Coolspring Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Girdltree, Md.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Gladys B. Stewart</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Clinton F. Stewart Salis. Md.</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CARDIORESPIRATORY ARREST</b>   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| b. <b>RIGHT CEREBRAL HEMISPHERIC STROKE</b>  |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| c. <b>HEPATIC FAILURE</b>  |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| d. <b>RENAL FAILURE</b>  |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| e. <b>CHRONIC ALCOHOLISM</b>   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Mark Speake MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D36708</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-4-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARK SPEAKE MD MOUNT VERNON ROAD PRINCESS ANNE, MD 21853</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 06 90</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>J. A. [Signature]</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 08763

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Thelma Beatrice Andrews   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March 15, 1990   |  | 3. TIME OF DEATH<br>M  |  |
| 4. SOCIAL SECURITY NUMBER<br>217-42-7688  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>89 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>June 19, 1900  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Pennsylvania  |  |  |  | 9a. FACILITY NAME (If not Institution, give street and number)<br>Washington County Hospital   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown  |  |
| 9c. COUNTY OF DEATH<br>Washington   |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Washington  |  |
| 10c. CITY, TOWN OR LOCATION<br>Hagerstown   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>136 North Avenue   |  |
| 10f. ZIP CODE<br>21740  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) 10 years College (1-4 or 5+)   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Home   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Aaron M. Stumbaugh   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Katherine Hays  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Ulmont H. Andrews   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>136 North Avenue Hagerstown, Maryland 21740   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Rest Haven Cemetery  |  |  |  |
| 20c. LOCATION — City or Town, State<br>Hagerstown, Maryland   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Gerald N. Minnich   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br>Gerald N. Minnich<br>Funeral Home   |  |  |  | 305 N. Potomac Street<br>Hagerstown, Maryland  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |  |  |  |  |  |  |
| a. Congestive Heart Failure   |  |  |  |  |  |  |  |
| b. Ischemic Heart Disease   |  |  |  |  |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  |
| 28b. TIME OF INJURY<br>M  |  |  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER<br>(Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>J. Davidson  |  |  |  | 29c. LICENSE NUMBER<br>D21457  |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br>3/16/90  |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>ABDUL WATHERD, JR. 1610 Oak Hill Ave. Hagerstown MD   |  |  |  |
| 31. DATE (Month, Day, Year)<br>MAR 19 90  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>J. Davidson   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Allen M. Avery, Sr.  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>03 19 1990   |  | 3. TIME OF DEATH<br>2:30AM M   |   |
| 4. SOCIAL SECURITY NUMBER<br>093-12-9281   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>82 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>May 8, 1907   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>New York   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Montgomery General Hospital  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Olney   |   |
| 9c. COUNTY OF DEATH<br>Montgomery  |  |  |  | 10a. STATE<br>D.C.   |  | 10b. COUNTY<br>None  |   |
| 10c. CITY, TOWN OR LOCATION<br>Washington  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>2330 Good Hope Road S.E.   |   |
| 10f. ZIP CODE<br>20020   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) College (1-4 or 5+)<br>4  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Dir. of Community Rel.   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>D.C. Dept. of Corrections  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>George Tom Avery  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Sarah Williams  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Allen M. Avery, Jr.  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10141 Riggs Road, Adelphi, Maryland 20783   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Maryland National Memorial Park  |  | 20c. LOCATION — City or Town, State<br>Laurel, Maryland  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John M. Brown</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>McGuire Funeral Service, Inc.<br>7400 Georgia Ave. N.W., Washington, D.C.  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>RESPIRATORY FAILURE</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>BILATERAL PNEUMONIA DUE TO STAPH. AUREUS</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>ACUTE RENAL FAILURE</u><br><u>MULTI-INFARCT DEMENTIA</u>  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>T. E. Howe, M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br>D33700  |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-19-90   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>TED E. HOWE, M.D. XXXX 18100 MARDEN LANE, OLNEY, MD. XXXX 20832   |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>MAR 22 '90  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general introduction to the subject of the study.

2. The second part of the report is a detailed description of the methods used in the study.

3. The third part of the report is a discussion of the results of the study.

4. The fourth part of the report is a conclusion.

5. The fifth part of the report is a list of references.

6. The sixth part of the report is a list of tables.

7. The seventh part of the report is a list of figures.

8. The eighth part of the report is a list of appendices.

9. The ninth part of the report is a list of footnotes.

10. The tenth part of the report is a list of errata.

11. The eleventh part of the report is a list of acknowledgments.

12. The twelfth part of the report is a list of abbreviations.

13. The thirteenth part of the report is a list of symbols.

14. The fourteenth part of the report is a list of units.

15. The fifteenth part of the report is a list of constants.

16. The sixteenth part of the report is a list of definitions.

17. The seventeenth part of the report is a list of notes.

18. The eighteenth part of the report is a list of references.

19. The nineteenth part of the report is a list of errata.

90 08765

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HELEN (Helene) Agnes ALDERTON</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 19, 1990</b>   |  | 3. TIME OF DEATH<br><b>6:40 A. M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-07-6327</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>April 27, 1907</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Memorial Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cumberland</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Allegany</b>  |  |  |  | 10a. STATE<br><b>Md.</b>  |  | 10b. COUNTY<br><b>Allegany</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Cumberland</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>229 Baltimore Ave.</b>  |  |
| 10f. ZIP CODE<br><b>21502</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Bookkeeper</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Retail</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Emory Twigg</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Cora Mae Haugh</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Eden M. Fike</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10510 Vincent Farm Lane White Marsh, Md. 21162</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                     |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Hillcrest Burial Park</b>  |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>Cumberland, Md.</b>   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert C. Adams</b>   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Silcox-Merritt Funeral Service<br/>404 Decatur St. Cumberland, Md. 21502</b>   |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Aspiration Pneumonia</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Cerebrovascular Accident</b> |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>March 19, 1990</b>   |  |  |  |
| 28b. TIME OF INJURY<br><b>M</b>   |  |  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dr. Sunil Gupta</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D 33280</b>   |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>3/19/90</b>   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Sunil Gupta, Memorial Hospital Medical Building, Cumberland, MD 21502</b>   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 21 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DATE: 10/10/10



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial final permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90-08766

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Wilbur Ray Allen  |  |  |  | 2. DATE OF DEATH<br>3-14-90   |  | 3. TIME OF DEATH<br>2:40A M   |  |
| 4. SOCIAL SECURITY NUMBER<br>217-44-0083  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 8. AGE (In yrs. ias. birthday)<br>73 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>07-18-16   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Greater Laurel-Beltsville M.C.  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Laurel   |  | 9c. COUNTY OF DEATH<br>Prince George  |  |
| 10a. STATE<br>MD  |  | 10b. COUNTY<br>Anne Arundel  |  | 10c. CITY, TOWN OR LOCATION<br>Mayo   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br>Box 51 Bayside Drive  |  |  |  | 10f. ZIP CODE<br>21106  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WWII  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Lawyer/Attorney   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Law-US Gov't.   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Ray Harvey Allen   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Lucie M. Wagner  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Karen F. Allen  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Box 51 Bayside Drive, Mayo, 21106  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Metro Crematory  |  | 20c. LOCATION — City or Town, State<br>Baltimore, MD  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Hardesty Funeral Home P.A.<br>12 Ridgely Avenue, Annapolis, MD  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <i>Metastatic Adenocarcinoma of Pancreas</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  | Approximate Interval Between Onset and Death<br>3 3/4 yrs   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)<br><br>  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><br>  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><br>  |  |   |  |
| 29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                    |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  | 29c. LICENSE NUMBER<br>D08754   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3/14/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Thomas A. Bensinger 7525 Greenway Ctr Dr. Greenbelt MD 20770   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 15 1990  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |   |  |





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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <b>HELEN LEONA ATCHISON</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>6</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>6 35 A</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>402-09-4696</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><b>81</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>7-21-08</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>1421 Taney Avenue</b>   |  |  |  | 10f. ZIP CODE<br><b>21701</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4 or 5+) <b></b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Bookkeeper</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>None</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Henry Medley Head</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Stella B. Tandy</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Dr. William F. Atchison</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10711 Gatewood Ave. Silver Spring, Md. 20903</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory</b>  |  | 20c. LOCATION — City or Town, State<br><b>Smithsburg, Md.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert E. Dailey</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A.<br/>1201 N. Market St. Frederick, Md. 21701</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CARDIOGENIC SHOCK</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. CONGESTIVE HEART FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b> |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>5 DAYS</b><br><b>5 DAYS</b><br><b>5 DAYS</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETES</b>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Sheema Kahan MD</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>1</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1-6-90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>S KAHAN 4 W 7th ST FREDERICK MD 21701</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 08 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |  |
|--|--|--|--|---|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Shirley Anne AUSHERMAN</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>17</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>0135</b> <sup>A</sup>  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-28-1061</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>55</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Jan. 29, 1934</b>                                  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |  |
| 10e. STREET AND NUMBER<br><b>4330 Araby Church Road</b>  |  |  |  | 10f. ZIP CODE<br><b>21701</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Bank Teller</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Savings Bank</b>   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Harold R. Lydard</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Dorothy Morningstar</b>   |  |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Donald LeRoy Ausherman</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4330 Araby Church Road, Frederick, Md. 21701</b>  |  |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mount Olivet Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Frederick, Maryland</b>   |  |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Richard C.C. Basford</i> M00021  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney and Basford Funeral Home</b><br><b>106 East Church St., Frederick, Md. 21701</b>  |  |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. perforation of hollow viscus</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>b. adenocarcinoma lung</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. cord compression</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d. diabetes mellitus</b> |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>2 mo</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br><br><br>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |   |  |
|  |  | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |   |  |
|  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>0146 26</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/17/90</b>   |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. M. A. Rausch 501 West South Frederick Md 21701</b>   |  |  |  |   |  |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 18 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>HERMAN William AYLOR   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>1-18-90   |  | 3. TIME OF DEATH<br>5:41PM M   |   |
| 4. SOCIAL SECURITY NUMBER<br>215-42-3331   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>45 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>March 9, 1944                              |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Virginia   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>FREDERICK MEMORIAL HOSPITAL   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>FREDERICK                                     |   |
| 9c. COUNTY OF DEATH<br>FREDERICK COUNTY  |  |  |  | 10a. STATE<br>Maryland  |  |  |   |
| 10b. COUNTY<br>Frederick   |  |  |  | 10c. CITY, TOWN OR LOCATION<br>Frederick  |  |  |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br>5341 Reel's Mill Road   |  |  |   |
| 10f. ZIP CODE<br>21701   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>1962-1965  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Comptroller   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Roofing and Construction Company  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Charles F. O'Brien  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Martha Lee Aylor Rhodes  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Patricia Ann Aylor   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5341 Reel's Mill Rd., Frederick, Md. 21701   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Resthaven Memorial Gardens   |  | 20c. LOCATION — City or Town, State<br>Frederick, Md. 21701   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Richard C. C. Basford 190021  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Keeney and Basford Funeral Home<br>106 East Church St., Frederick, Md. 21701  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Mario F. Golle, Jr.   |  |  |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>1-19-90                                       |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARIO F. GOLLE, JR., MD 111 Penn Street, Baltimore, MD 21201 vc   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>JAN 19 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Florence C. Arnold</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>2</b> / DAY <b>14</b> / YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>7:10 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>036-22-3081</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>92</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>July 23, 1897</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>New York City</b>  |  |  |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>140 Fairview Ave.</b>  |  |  |  | 10f. ZIP CODE<br><b>21701</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                          |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Teacher</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Education</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James A. Cook</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Christine Mehringer</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Dr. William Arnold</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>140 Fairview Ave., Frederick, Md. 21701</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Long Island National Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Pinelawn, New York</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Richard E. Gray</b> MO0255  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney &amp; Basford P.A. Funeral Home</b><br><b>106 East Church St., Frederick, Md. 21701</b>  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>s. CARDIO RESPIRATORY ARREST</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST:<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Carmen R. Skerding</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 35271</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/14/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>310 WEST 9TH ST FREDERICK MD 21701</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 14 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

Page 1 of 1

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1861. It is a very important document, as it is the first official communication from the President to the Congress since the inauguration.

2. The second part of the document is a report from the Secretary of the Treasury, dated January 1, 1861. It contains a detailed account of the financial condition of the United States at the time of the inauguration.

Handwritten signature and date: 1861



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Eva Elizabeth Abrecht</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 14, 1990</b>   |  | 3. TIME OF DEATH<br><b>2:30 A. M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-78-3993</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (in yrs. last birthday)<br><b>80</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>July 19, 1909</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Meridian Nursing Center</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Frederick</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Frederick</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>407 Braddock Avenue</b>   |  |
| 10f. ZIP CODE<br><b>21701</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>Homemaker</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Lawrence L. Ingram</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Golden Elizabeth Haines</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ernest A. Abrecht III</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6813 Mountindale Rd., Frederick, Md. 21701</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mount Olivet Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Frederick, Maryland</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert C. C. C.</i> M00021   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney and Basford Funeral Home</b><br><b>106 East Church St., Frederick, Md. 21701</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alzheimer's Disease</b>   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>George I. Smith Jr.</i> Dr.  |  |  |  | 29c. LICENSE NUMBER<br><b>D10587</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/14/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. George I. Smith, Jr., 300 West Ninth St., Frederick, Md. 21701</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 16 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Brenda Sue Ackley</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb 22, 1990</b>   |  | 3. TIME OF DEATH<br>M<br><b>2120</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>234-74-8541</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>40</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>May 10, 1949</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>W. Virginia</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Shady Grove Adventist Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Gaithersburg</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>#19 Nancy Place</b>   |  |
| 10f. ZIP CODE<br><b>20877</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>American</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4 or 5+) <b>Program Analyst</b>  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>U.S. Government</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Government</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John R. Hagerman</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ruby B. Hankins</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Tina F. Ackley</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13208 Bristlecone Way #12, Germantown, Md. 20874</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Hagerman Cemetery</b>  |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>Jolo, W. Virginia</b>  |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert L. Williams</i>  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Olin L. Molesworth, P.A., Funeral Home<br/>Damascus, Maryland 20872</b>   |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Cervical Cancer</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal Failure due to obstructing cancer</b> |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>Feb 22, 1990</b>   |  |  |  |
| 28b. TIME OF INJURY<br>M<br><b>2120</b>  |  |  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D29675</b>  |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>2/23/90</b>  |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Ralph V. Bocca, MD 14808 PHYSICIANS IN Rockville, MD.</b>   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 26, 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |   |
|---|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOSEPH ALOYSIUS AHERN</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 12, 1990</b>   |  | 3. TIME OF DEATH<br>HOURS MIN.<br><b>8:10 A. M.</b>                                  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>577-22-1219</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>67</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MARCH 21, 1922</b>                         |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>WASHINGTON, D.C.</b>   |  |   |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br><b>SILVER SPRING</b>   |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |   |
| 9b. FACILITY NAME (If not institution, give street and number)<br><b>318 ST. LAWRENCE DRIVE</b>   |  |   |  |   |  |  |   |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |  |   |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>MONTGOMERY</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>SILVER SPRING</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>318 ST. LAWRENCE DRIVE</b>   |  |   |  | 10f. ZIP CODE<br><b>20901</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>           |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>FOREIGN SERVICE AIDE OFFICER U.S. STATE DEPARTMENT</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>PATRICK J. AHERN</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ELIZABETH OTIS</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARTHA M. AHERN (WIFE)</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>318 ST. LAWRENCE DRIVE, SILVER SPRING, MARYLAND 20901</b>                                   |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GATE OF HEAVEN CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>SILVER SPRING, MARYLAND</b>   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Francis J. Collins</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W., SIL. SP., MD 20901</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CHRONIC OBSTRUCTIVE PULMONARY Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d.</b> |  |   |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cleared with Medical Examiner</b>  |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |
|   |  |   |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO     |   |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Bernard A. Fitzgerald</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>D04373</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-12-90</b>                                |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>BERNARD A. FITZGERALD, M.D. 217 UNIVERSITY BLVD., EAST, SILVER SPRING, MD 20901</b>   |  |   |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 16 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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90 08774

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ZILPAH H. ANDERSON</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>18</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>9:05 A</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-34-6955</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>92</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Dec. 20, 1897</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>GA</b>  |  |  |  | 9. FACILITY NAME (If not institution, give street and number)<br><b>HOLY CROSS HOSPITAL</b>  |  | 10. CITY, TOWN OR LOCATION OF DEATH<br><b>SILVER SPRING</b>   |  |
| 11. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |  |  |  | 12. STATE<br><b>MD</b>   |  | 13. CITY, TOWN OR LOCATION<br><b>Gaithersburg</b>   |  |
| 14. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 15. STREET AND NUMBER<br><b>9701 Fields Rd. # 901</b>  |  | 16. ZIP CODE<br><b>20878</b>  |  |
| 17. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  | 18. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 19. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 21. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  | 22. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (8-12)</b>  |  |
| 23. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  |  |  | 24. KIND OF BUSINESS/INDUSTRY<br><b>At Home</b>  |  | 25. FATHER'S NAME (First, Middle, Last)<br><b>George Monroe Huie</b>  |  |
| 26. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mattie McConnell</b>   |  |  |  | 27. INFORMANT'S NAME (Type/Print)<br><b>Dorothy G. Travis</b>  |  | 28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3825 N. Roberts Lane Ar., VA 22207</b>       |  |
| 29. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 30. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Parklawn Mem. Park Cem.</b>  |  | 31. LOCATION — City or Town, State<br><b>Rockville, MD</b>  |  |
| 32. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Michael E. Nelson</b>  |  |  |  | 33. NAME AND ADDRESS OF FACILITY<br><b>Joseph Gawler's Sons, Inc.<br/>5130 WI Ave. NW Wash., DC 20016</b>  |  |   |  |
| 34. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Gram Positive Sepsis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. chronic obstructive Pulmonary Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |  |  |   |  |
| 35. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>24a. WAS AN AUTOPSY PERFORMED?</b><br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><b>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?</b><br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |  |  |   |  |
| 36. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 37. PLACE OF DEATH (Check only one)<br><b>HOSPITAL:</b><br><input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br><b>OTHER:</b><br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  |
| 38. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  |  |  | 39. DATE OF INJURY (Month, Day, Year)<br><b>3.18.90</b>  |  | 40. TIME OF INJURY<br><b>M</b>  |  |
| 41. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>9801 Georgia Ave Silver Spring MD 20902</b>  |  |  |  | 42. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 43. DESCRIBE HOW INJURY OCCURRED  |  |
| 44. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 45. CERTIFIER<br>(Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| 46. SIGNATURE AND TITLE OF CERTIFIER<br><b>Julia Davidson-Rendall</b>  |  |  |  | 47. LICENSE NUMBER<br><b>D13548</b>  |  | 48. DATE SIGNED (Month, Day, Year)<br><b>3.18.90</b>  |  |
| 49. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>RATINDRA K. SPRIN</b>  |  |  |  | 50. DATE FILED (Month, Day, Year)<br><b>3.18.90</b>  |  |   |  |
| 51. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rendall</b>   |  |  |  | 52. DATE<br><b>MAR 20 '90</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be retained by the funeral director. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.





ITEM:17 per FH G-662  
4-30-90 cm

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1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BERTHA ELIZABETH ARMSTRONG</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 10 1990</b>  |  | 3. TIME OF DEATH<br><b>7:05p</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>577-26-5982</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>86</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JULY 8, 1903</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>PHYSICIANS MEMORIAL HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>LAPLATA</b>   |  | 9c. COUNTY OF DEATH<br><b>CHARLES</b>  |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>CHARLES</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>WALDORF</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>802 STONE AVENUE</b>  |  |  |  | 10f. ZIP CODE<br><b>20601</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12)<br><b>8TH GRADE</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>N/A</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>HUGH HARRY ARMSTRONG JACOB STEELE</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY ELLEN ARNOLD</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>HUGH PERRY ARMSTRONG</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. BOX 69, CHAPTICO, MARYLAND 20621</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>TRINITY MEMORIAL GARDENS</b>                                    |  | 20c. LOCATION — City or Town, State<br><b>WALDORF, MARYLAND</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>THE HUNTT FUNERAL HOME, INC.<br/>P.O. BOX 156, WALDORF, MARYLAND 20604-0156</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebrovascular accident</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <b>Arteriosclerosis</b><br>b. <b>Ischemic bowel disease</b><br>c. <b>Hypertension</b><br>d. <b>Hypertension</b> |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>24 hr</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes mellitus, chronic, hyperlipidemia, peptic ulcer disease, cardiac arrhythmia, transient ischemic attack, seizure</b>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> M.D.   |  |
| 29c. LICENSE NUMBER<br><b>D08370</b>   |  |  |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/11/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>PAUL E. PRITCHETT M.D.<br/>118 LAGRANGE AVENUE POB 1317<br/>LAPLATA MARYLAND 20646</b>   |  |  |  |   |  | 31. DATE FILED (Month, Day, Year)<br><b>MAR 13 '90</b>   |  |
| 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |   |  | 33. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Information is not to be used for purposes of  
the above mentioned project and is not to be  
used for any other purpose.

1. The above information is not to be used for  
any other purpose.

90 08776

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EDITH ARMACOST</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>25</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>750 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>320-16-1940</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>92</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>8-24-1897</b>   |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>Long View Nursing Home</b>  |  |  |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br><b>Manchester</b>  |  | 9c. COUNTY OF DEATH<br><b>Carroll</b>   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Carroll</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Hampstead</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>4512 Upper Beckleysville Rd.</b>   |  |  |  | 10f. ZIP CODE<br><b>21074</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b><br>College (1-4 or 5+)   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>  |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Home Making</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Edward Rusthon</b>  |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Unknown</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Virginia Bell</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4515 Beckleysville Rd Hampstead, Md 21074</b>  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Grave Run Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Hampstead, Md.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>R. Larry Nightingale</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Eckhardt Funeral Chapel<br/>Manchester, Md. 21102</b>  |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart Failure</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><div style="display: flex; justify-content: space-between;"> <div> <b>Organic Brain Syndrome</b><br/> <b>generalized arteriosclerosis</b> </div> <div> <b>5 yrs</b><br/> <b>5 yrs</b> </div> </div> |  |  |  |   |  |   | Approximate interval Between Onset and Death<br><b>1 Mo</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
|   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|   |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>W. H. Ford MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D02386</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-25-1990</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>W. H. Ford MD 3223 Main St. Box 50 Manchester, Md</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 26 90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Alexander A. Boykin</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> - <b>1</b> DAY <b>1990</b> YEAR  |  | 3. TIME OF DEATH<br><b>6:23</b> <b>AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>265-01-2808</b>   |  | 6. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>11-10-1919</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>At Home Rt. 1 Box 96</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Tyaskin, Md.</b>  |  | 9c. COUNTY OF DEATH<br><b>Wicomico</b>   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |  |
| 10a. STATE<br><b>Md.</b>  |  | 10b. COUNTY<br><b>Wicomico</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Tyaskin</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>Rt. 1 Box 96</b>   |  |  |  | 10f. ZIP CODE<br><b>21865</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) _____  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Painter</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Self Employed</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Alexander Boykin</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Alberta ----</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Cristine V. Boykin</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Rt. 1 Box 96 Tyaskin, Maryland 21865</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Grace Church Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>New Town, Maryland</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Cornelius D. Messick II</i> <b>MD0417</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Messick Funeral Home, P.O. Box 61<br/>Bivalve, Maryland 21814</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lung cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____ |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>6 month</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____<br>_____  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br>_____  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>_____   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>_____   |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Stephen H. Caffey M.D.</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D20683</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/3/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>STEPHEN H. CAFFEY, M.D., Nanticoke, Md 21840</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 05 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davis</i>  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Mary Duvall Brown  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>02 01 90  |  | 3. TIME OF DEATH<br>2044 M   |  |
| 4. SOCIAL SECURITY NUMBER<br>232-26-4957   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>75 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>02/28/1914                                 |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>W. Va. Berkeley County   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Frederick Memorial Hospital   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick                                     |  |
| 9c. COUNTY OF DEATH<br>Frederick   |  |  |  | 10a. STATE<br>Maryland  |  |  |  |
| 10b. COUNTY<br>Frederick   |  |  |  | 10c. CITY, TOWN OR LOCATION<br>Brunswick  |  |  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br>20 Gum Spring Road  |  |  |  |
| 10f. ZIP CODE<br>21716   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>11  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Housewife   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Homemaker   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Lee Allen Marshall  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Cary Alice Bromley   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Charles R. Brown   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>20 Gum Spring Road, Brunswick, Maryland 21716  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Edge Hill Cemetery   |  | 20c. LOCATION — City or Town, State<br>Charles Town, W. Va.   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Barbara A. Williams, Funeral Dir.   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>John T. Williams Funeral Home<br>100 Petersville Rd., Brunswick, MD 21716   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. CHRONIC PULMONARY DISEASE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. RENAL FAILURE ON DIALYSIS<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. DIABETES MELLITUS<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>MUCOUS PULMONARY PLUG  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Robert R R Roberts MD   |  |  |  | 29c. LICENSE NUMBER<br>D09867   |  | 29d. DATE SIGNED (Month, Day, Year)<br>02/01/90                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>RRR ROBERTS MD 15 W 7th St Frederick MD 21701-4599  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 12 1990   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LETHA CATHERINE BOHN</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>03</b> DAY <b>22</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>3:45A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-34-0788B</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>87 YRS.</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11/18/02</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>FREDERICK MEMORIAL HOSPITAL</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>FREDERICK</b>   |  | 9c. COUNTY OF DEATH<br><b>FREDERICK</b>   |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>FREDERICK</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>FREDERICK</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>1603 ROSEMONT AVENUE</b>  |  |   |  | 10f. ZIP CODE<br><b>21701</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b><br>College (1-4 or 5+) <b>College (1-4 or 5+)</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>EMMANUEL ELLSWORTH BLAXSTEN</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>SADIE BLACK</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CLYDE M. BOHN, JR.</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. BOX 190 WOODSBORO, MD 21798</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>PIPE CREEK CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>UNIONTOWN, MD</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert E. Dailey</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, PA<br/>1201 NORTH MARKET ST. FREDERICK, MD 21701</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Myocardial Infarction</i>   |  |   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF): <i>Myocardial Infarction</i>  |  |   |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Renal insufficiency</i><br><i>Hypertension</i>  |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |   |  |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Robert L. Kaufmann</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>D-13971</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/23/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ROBERT L. KAUFMANN, MD 300 WEST 9th STREET FREDERICK, MD 21701</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 23 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

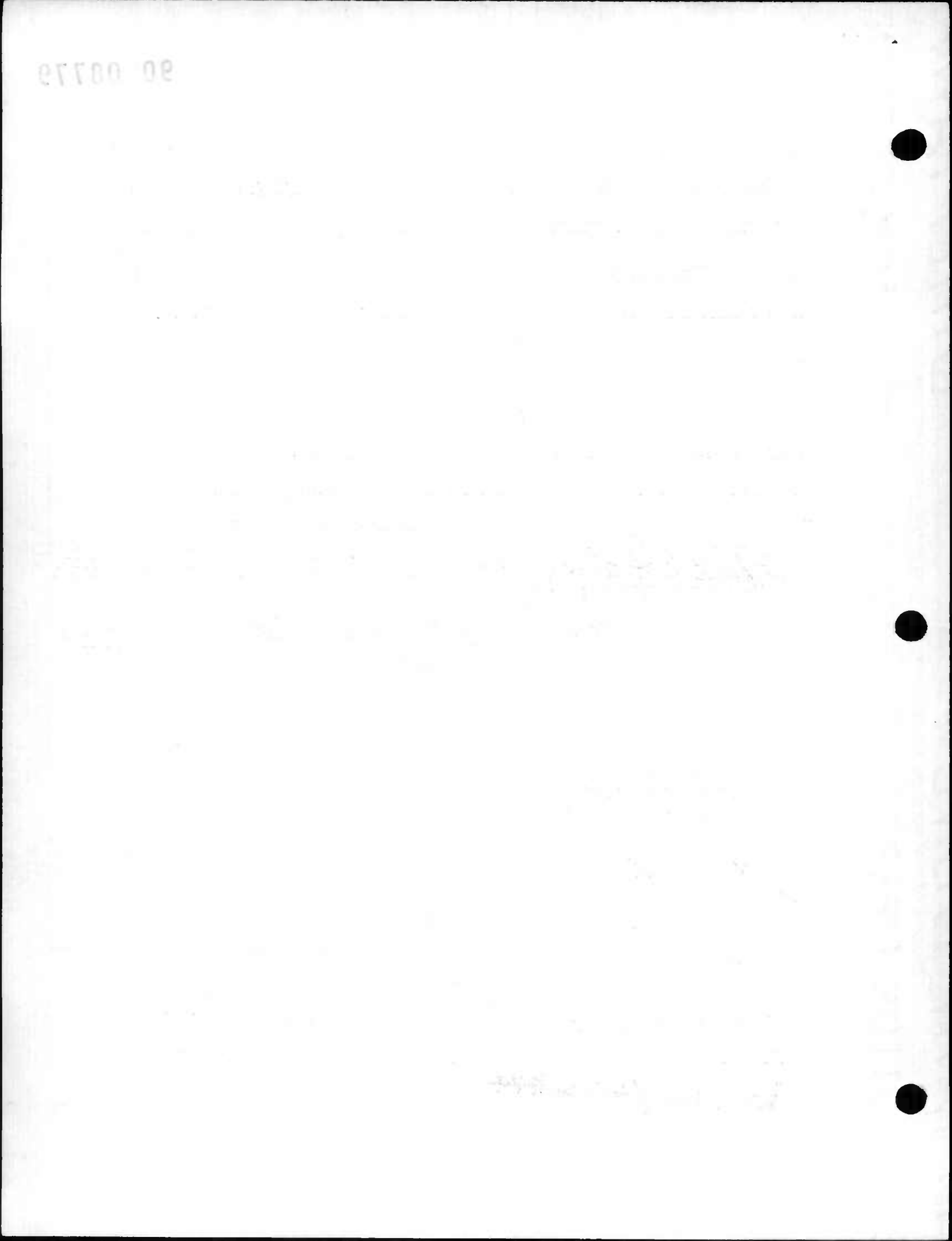
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


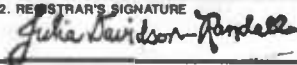
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Helen Rosetti Bean</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 19, 1990</b>   |  | 3. TIME OF DEATH<br><b>1:15 P.</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-50-2171</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Feb. 28, 1915</b>                                    |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Middletown</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>102 E. Green St.</b>  |  |  |  | 10f. ZIP CODE<br><b>21769</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                           |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>homemaker</b>                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>own home</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William C. Puckett</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ruby Brown</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Weldon L. Bean</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>102 E. Green St., Middletown, Md. 21769</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory</b>  |  | 20c. LOCATION — City or Town, State<br><b>Smithsburg, Md.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Donald B. Thompson Funeral Home<br/>31 E. Main St., Middletown, Md. 21769</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cardiac Arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. Atherosclerosis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b> |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |   |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Michael Behre MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D16939</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/20/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Michael Behre MD</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 23 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br>                                 |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Mehrl Eli BIERLEY   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3 5 90  |  | 3. TIME OF DEATH<br>0520 A  |   |
| 4. SOCIAL SECURITY NUMBER<br>217-12-8397  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>86 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Sept. 16, 1903                              |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Frederick Memorial Hospital   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick  |  | 9c. COUNTY OF DEATH<br>Frederick  |   |
| 10a. STATE<br>Maryland  |  |  |  | 10b. COUNTY<br>Frederick  |  | 10c. CITY, TOWN OR LOCATION<br>Frederick  |   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br>268 West Fifth Street   |  |   |   |
| 10f. ZIP CODE<br>21701  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                   |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) 7 College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Owned & Operated  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Marine Sales  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Charles Emory Bierley  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Sarah Elizabeth Wachter  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Ruth Bierley   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>268 West 5th Street, Frederick, Maryland 21701   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mount Olivet Cemetery  |  | 20c. LOCATION — City or Town, State<br>Frederick, Maryland  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Richard E. Gray M00255   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Keeney and Basford P.A. Funeral Home<br>106 East Church St., Frederick, Md. 21701   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <u>Cardiovascular Arrest</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>Cerebrovascular Accident, Infection</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <u>Stroke, fibrillation, chronic</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)          |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Arthur G. Morrow, M.D.   |  |  |  | 29c. LICENSE NUMBER<br>D-18191  |  | 29d. DATE SIGNED (Month, Day, Year)<br>3/5/90   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Arthur G. Morrow, M.D. 187 Thomas Johnson Dr. Frederick, Md. 21701   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>MAR 06 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNITED STATES OF AMERICA

DO hereby certify that

the following is a true and correct copy of

the original as the same appears on the records of

the Department of the Interior

at Washington, D. C.

this 10th day of May 1908

W. A. RORER, Secretary of the Interior

By \_\_\_\_\_

Assistant Secretary of the Interior

W. A. RORER, Secretary of the Interior

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Evelyn Jane Burdette</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>8</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>05 29 A M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>218-30-3511</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>4-5-09</b>                                 |   |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>FREDERICK MEMORIAL HOSP.</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>FREDERICK</b>   |  | 9c. COUNTY OF DEATH<br><b>FREDERICK</b>  |   |
| 10a. STATE<br><b>MARYLAND</b>  |  |  |  | 10b. COUNTY<br><b>MONTGOMERY</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>DICKERSON</b>                                      |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>22125 Dickerson School Rd.</b>   |  |  |   |
| 10f. ZIP CODE<br><b>20842</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>              |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th</b> College (1-4 or 5+) <b></b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>MILTON URNER BURDETTE</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lulu Thompson</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>William Burdette</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>22125 Dickerson School Rd. Dickerson, Md. 20842</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Needsville Church</b>   |  | 20c. LOCATION — City or Town, State<br><b>GERMANTOWN</b>  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Will. D. Nish</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HILTON FUNERAL HOME<br/>2211 BEACSVILLE RD.<br/>BARNESVILLE, Md. 21038</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |  |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Justin P. ...</b>  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/8/90</b>                                 |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 09 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SECRET



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Charles James Boone</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>03</b> DAY <b>02</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>1650</b> <b>M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-10-1003</b>   |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Dec. 28, 1910</b>                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>  |  |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>Frederick</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Braddock Heights</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>5022 Old National Pike</b>   |  |  |  | 10f. ZIP CODE<br><b>21701</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br><b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Brakeman</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>B &amp; O Railroad</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Franklin Locke</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Clara Coveil</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Madeline Boone</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5022 Old National Pike, Frederick, Md. 21701</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Lutheran Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Middletown, Maryland</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Richard E. Thaf</b> <b>MO0255</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney &amp; Basford P.A. Funeral Home</b><br><b>106 East Church Street, Frederick, Md. 21701</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>Coronary Artery Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Coronary Artery Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Syst. Arteriosclerosis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Cardiogenic Shock w/ P. S. M. 2/4/90</b><br>Approximate Interval Between Onset and Death<br><b>8 yrs.</b><br><b>2 yrs.</b><br><b>2 yrs.</b><br><b>12 Hrs.</b> |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Robert L. Kaufmann MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D-13971</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/4/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Robert L. Kaufmann, MD 300 West Ninth Street, Frederick, Md. 21701</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 05 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MAY VIRGINIA BRIDGE   |  |  |  | 2. DATE OF DEATH<br>MONTH 03 DAY 13 YEAR 90   |  | 3. TIME OF DEATH<br>11:47 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>225-46-3135  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>7 7 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>12/18/1912   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Frederick Memorial Hospital   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick  |  | 9c. COUNTY OF DEATH<br>Frederick  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |
| 10a. STATE<br>MD  |  | 10b. COUNTY<br>Frederick   |  | 10c. CITY, TOWN OR LOCATION<br>Frederick  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>5625 Butterfly Lane   |  |  |  | 10f. ZIP CODE<br>21701  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6<br>College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker                       |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>William Lester Schooley  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>May Curl   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mr. Theodore R. Bridge  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5625 Butterfly Lane Frederick, MD 21701  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Smithsburg Crematory   |  | 20c. LOCATION — City or Town, State<br>Smithsburg, MD   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert E. Dailey</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Robert E. Dailey & Son Funeral Homes, PA<br>1201 North Market St. Frederick, MD 21701   |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Congestive Heart Failure</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. _____ DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____ DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____ |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Myocardial Infarction, Pneumonia, Diabetes Mellitus.</u>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other (Specify)  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J. Pasierb MD</i>   |  |  |  | 29c. LICENSE NUMBER<br>D35553   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3/14/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Judith Pasierb, MD 4014 Mountville Road Jefferson, MD 21755  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 14 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |   |
|---|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Charles. Bowie III</i>   |  |   |  | 2. DATE OF DEATH<br>MONTH <i>3</i> - DAY <i>12</i> - YEAR <i>90</i>   |  | 3. TIME OF DEATH<br><i>7:19 AM</i>   |   |
| 4. SOCIAL SECURITY NUMBER<br><i>220-01-0663</i>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><i>69</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>6-5-1920</i>                    |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>MD.</i>  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Frederick Memorial Hospital</i>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Frederick</i>                      |   |
| 9c. COUNTY OF DEATH<br><i>Frederick</i>   |  |   |  | 10a. STATE<br><i>MD.</i>  |  |  |   |
| 10b. COUNTY<br><i>Frederick</i>   |  |   |  | 10c. CITY, TOWN OR LOCATION<br><i>Frederick</i>   |  |  |   |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br><i>464 W. South St.</i>   |  |  |   |
| 10f. ZIP CODE<br><i>21701</i>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><i>WWII</i>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>Black</i>      |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Medical technician</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Government</i>   |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Charles D. Bowie, II</i>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Hazel Liason</i>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Dorothy Bowie</i>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>464 W. South St., Frederick, Md 21701</i>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Resthaven Memorial Gardens</i>   |  | 20c. LOCATION — City or Town, State<br><i>Frederick, Md.</i>  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Donald L. Lemmer</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Stauffer Funeral Home<br/>1621 Opossumtown Pike, Frederick, MD.</i>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Carcinoma of Lung</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |  | Approximate interval Between Onset and Death<br><i>9 mos</i>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>  |   |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Robert L. Kaufman, MD</i>   |  |   |  | 29c. LICENSE NUMBER<br><i>D-13971</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>3/12/90</i>                        |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |   |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><i>MAR 13 1990</i>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Gail Davidson-Randall</i>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 08786

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |  |                                |  |  |
|--|--|--|---|--|--------------------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Dorothy (Farris) Bunn  |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>2/24/90  |                                | 3. TIME OF DEATH<br>12:00 PM   |  |
| 4. SOCIAL SECURITY NUMBER<br>212-76-4482   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br>81 YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year)<br>Sept 6, 1908  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Missouri   |  |  |   | 9a. FACILITY NAME (If not institution, give street and number)<br>10022 Bethel Road  |                                | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick   |  |
| 9c. COUNTY OF DEATH<br>Frederick   |  |  |   | 10a. STATE<br>Maryland   |                                | 10b. COUNTY<br>Frederick   |  |
| 10c. CITY, TOWN OR LOCATION<br>Frederick   |  |  |   | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |                                | 10e. STREET AND NUMBER<br>10022 Bethel Road  |  |
| 10f. ZIP CODE<br>21701   |  |  |   | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |                                | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>white  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  |  |   | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker  |                                | 16b. KIND OF BUSINESS/INDUSTRY<br>Own home   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Wilbur N. Farris  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Helen D. Ohlbrecht  |                                |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Michael D. Bunn  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10022 Bethel Rd., Frederick, Maryland 21701   |                                |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |   | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Resthaven Memorial Gardens   |                                | 20c. LOCATION — City or Town, State<br>Frederick, Md.  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Sharon Canale Clinic  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>1621 Opossumtown Pike, Frederick, Md.<br>21701   |                                |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Coronary atherosclerosis</u><br>b. <u>Excess hypertension</u><br>c. <u>Diabetes mellitus</u><br>d. <u>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</u><br>Approximate Interval Between Onset and Death<br>12h |  |  |   |  |                                |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  |                                |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |                                |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |   | 28a. DATE OF INJURY (Month, Day, Year)   |                                | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |   | 28d. DESCRIBE HOW INJURY OCCURRED  |                                | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |  |                                |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Robert J. Hughes, MD  |  |  |   | 29c. LICENSE NUMBER<br>D05111  |                                | 29d. DATE SIGNED (Month, Day, Year)<br>2/26/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |   |  |                                |  |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 27 1990   |  |  |   |  |                                |  |  |
| 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |  |   |  |                                |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BB BARNES</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>01</b> DAY <b>01</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>304 P</b>  |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>1-1-90</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>M.D.</b>  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Sinai Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br><b>M.D.</b>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>4341 Reisterstown Rd</b>  |  |  |  | 10f. ZIP CODE<br><b>21215</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>M.D.</b>  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>N/A</b><br>College (1-4 or 5+) <b>N/A</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>N/A</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>N/A</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Felicia Barnes</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>SINAI Hospital</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>SINAI Hospital</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>2401 W. BELVEDERE AVE</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Severe Prematurity / Immaturity</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>Birth</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Neelma Ragavan, Neonatologist</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 38265</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/1/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 30 1989</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>John BOLUS</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 22 90</b>  |  |  |  | 3. TIME OF DEATH<br><b>5:00</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>234-48-3512</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>66</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>June 10, 1923</b>                  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Lebanon</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Holy Cross Hosp. Silver Spg. Montgomery</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>1002 Loxford Terrace</b>   |  |   |  | 10f. ZIP CODE<br><b>20901</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>1-12</b> College (1-4 or 5+) <b>4 years</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>US Army</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Fed. Govt.</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Samuel Bolus</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Naime Mickel</b>  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Catherine M. Bolus</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1002 Loxford Terrace, Silver Spring, Md. 20901</b>  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Arlington National Cemetery Arlington, VA.</b>   |  |  |  | 20c. LOCATION — City or Town, State   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>[Signature]</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hines/Rinaldi Funeral Home<br/>11800 N.H. Ave., Silver Spring, Md. 20904</b>   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Myocardial Dis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>None</b>   |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28d. DESCRIBE NOW INJURY OCCURRED   |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>   |  |   |  |   |  | 29c. LICENSE NUMBER<br><b>109915</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>March 22, 1990</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John S. Rogers, MD 1919 Seminary Road, Silver Spring, Md. 20910</b>   |  |   |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 23 '90</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>RAYMOND NMN BARNHART</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>19</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>0930A</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>212-24-3151</b>  |  | 5. SEX<br><input type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>60</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 6, 1929</b>                                     |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Washington County Hospital</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>  |  | 9c. COUNTY OF DEATH<br><b>Washington</b>  |   |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |   |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Washington</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>717 Virginia Avenue</b>   |  |   |  | 10f. ZIP CODE<br><b>21740</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced<br><b>separated</b>  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                      |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b><br>College (13-16) <b>0</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>mail carrier</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Government</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Clinton Henry Barnhart</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Gertrude Timmons</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ethel Marie Barnhart</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Rt. 2, Box 84, Williamsport, Md. 21795</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Greenlawn Memorial Park</b>  |  | 20c. LOCATION — City or Town, State<br><b>Williamsport, Maryland</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Scott Minnich</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MINNICH FUNERAL HOME</b><br><b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>LACTIC ACIDOSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>CARDIAC FAILURE, RIGHT HEART FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>MITRAL STENOSIS, INOPERABLE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>Rheumatic fever (PROBABLE)</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br><b>6hr.</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
|  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>W E Macey M.D.</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>023815</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3.19.90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>3.20.90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Jane W. Wadsworth-Jones</b>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |  |  |   |  |   |  |
|--|--|--|--|--|--|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FLORENCE HELENA BROWN</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 20 90</b>   |  |  |  | 3. TIME OF DEATH<br>H M<br><b>10 20</b>  |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>081-16-2725</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>July 17, 1905</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>New York</b>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Leland Memorial Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Riverdale</b>  |  |  |  | 9c. COUNTY OF DEATH<br><b>Prince George's</b>  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Prince George's</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Hyattsville</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO        |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>5805 42nd Avenue, #516</b>  |  |  |  | 10f. ZIP CODE<br><b>20781</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                    |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b><br>College (1-4 or 5+) <b>None</b>   |  |  |  | 18a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Secretary</b>  |  |  |  | 18b. KIND OF BUSINESS/INDUSTRY<br><b>University of Maryland</b>  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles O. Finnblade</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Marion Falls</b>   |  |  |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Miriam D. Tucker (Daughter)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3800 Old Birdsville Road, Harwood, Maryland 20776</b>  |  |  |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery</b>   |  |  |  | 20c. LOCATION — City or Town, State<br><b>Brentwood, Maryland</b>  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE OFFICER<br><i>Francis Gasch</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Francis Gasch's Sons Funeral Home, P.A.<br/>4739 Baltimore Ave. Hyattsville, Md. 20781</b>  |  |  |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pulmonary Embolus</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Multiple Fractures</b><br>c. <b>Fall at Home</b><br>d. <b>10 days</b><br>e. <b>10 days</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |  |  |  |  |  |  | Approximate interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>None</b>  |  |  |  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>3/09/90</b>   |  | 28b. TIME OF INJURY<br><b>10:00 M</b>    |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO            |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Tripped &amp; Fell at Home</b>                                    |  |   |  |
|  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>Home</b>  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>516 Hyattsville, Md</b> |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John S. Rogers, M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>009975</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>March 21, 1990</b>  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John S. Rogers, M.D. 1919 Seminary Road, Silver Spring, Maryland 20910</b>   |  |  |  |  |  |  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 23 '90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>RUBY O. BROWN</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>11</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>2:21 A.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-30-2678</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>06/22/08</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>GREATER LAUREL BELTS HOSP.</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>LAUREL</b>  |  | 9c. COUNTY OF DEATH<br><b>PRINCE GEORGES</b>  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |
| 10a. STATE<br><b>MD.</b>  |  | 10b. COUNTY<br><b>016 Howard</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>LAUREL</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>12 FRANCES ST.</b>   |  |  |  | 10f. ZIP CODE<br><b>20707</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Grade 4</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>housewife</b>               |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>home</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Delbert Ray Worley</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Catherine Rebecca Dumhart</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Joseph Brown</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12 Frances Street, Laurel, Md 20723</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Emmanuel Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Scaggsville, Md</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Louise Douchon</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Donaldson Funeral Home, Laurel, Md</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>INFERRIOR MYOCARDIAL INFARCTION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CEREBROVASCULAR ACCIDENT, ORGANIC BRAIN SYNDROME</b>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29. CERTIFIER (Check only one)<br>1. <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29a. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D24035</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/11/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>IES MACHADO 321 PRINCE GEORGE ST</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 12 '90</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <b>ELMER CORNELIUS BARKER</b><br><i>Elmer Cornelius Barker</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>7</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>9 30 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-09-6295</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>8-1-15</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Denton Hospital &amp; Medical Center</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  |
| 9c. COUNTY OF DEATH<br><b>City</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Baltimore City</b>   |  |
| 10c. STREET AND NUMBER<br><b>3300 Benson Avenue</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. ZIP CODE<br><b>21227</b>  |  |
| 10f. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Printer</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Simpkins Industries</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Howard Clifton Barker</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Claire Kelly</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>M. Wayne Barker</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>704 Eastshire Drive, Baltimore, MD 21228</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <b>entombment</b>  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Crestlawn Memorial Gdns.</b>  |  | 20c. LOCATION — City or Town, State<br><b>Marriottsville, MD</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John Dallas Slack</i> <b>M00535</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Slack Funeral Home</b><br><b>Ellicott City, Maryland 21043</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Squamous Cell Carcinoma of the Lung</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive Heart Failure.</b><br><b>Chronic Obstructive Pulmonary Disease.</b>  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>George Taler</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D-19858</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/7/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>George Taler, M.D. 601 S. Charles St. Baltimore, Md. 21230</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 13 '90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOSEPH BUSH JOSEPH (nmn) BUSH</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>11</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>2:45 PM</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-94-0464</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>59</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>7 28 30</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Romania</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Fallston Gen Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Fallston</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Harford</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Harford</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Fallston Bel Air</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>6 Dublin Way</b>  |  |
| 10f. ZIP CODE<br><b>21014</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>Korea</b>   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Central Office Technician</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Telephone</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Johan — Busch</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Juliana — Wagner</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lorraine S. Bush</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6 Dublin Way, Bel Air, Md. 21014</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Bel Air Memorial Gardens</b>  |  | 20c. LOCATION — City or Town, State<br><b>Bel Air, Md.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Howard K. McComas III</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Howard K. McComas III Funeral Home, P.A.<br/>1317 Cokesbury Road, Abingdon, Md. 21009</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|  |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                             |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
|  |  |  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
|  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Richard J. Colfer</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>DO 1194</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/11/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>RICHARD J. COLFER 2013 Tappan Church Road<br/>Bel Air, Md 21034</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 1 3 '90</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |   |  |                                   |  |   |  |  |  |
|--|--|--|--|--|--|--|--|---|--|-----------------------------------|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EDITH B. BURTON</b>   |  |  |  | (Edith Belle Burton)   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>MARCH</b> DAY <b>19</b> YEAR <b>1990</b>   |  |                                   |  | 3. TIME OF DEATH<br><b>9:15 P M</b>   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-16-3635</b>  |  |  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 5. AGE (In yrs. last birthday)<br><b>68</b> YRS. |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>AUG. 30, 1921</b>   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>6 SUNSET LAKE TRAILER PARK</b>  |  |  |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BERLIN</b>  |  |                                   |  | 9c. COUNTY OF DEATH<br><b>WORCESTER</b>   |  |  |  |
| 10a. STATE<br><b>MARYLAND</b>  |  |  |  | 10b. COUNTY<br><b>WORCESTER</b>  |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>BERLIN</b>  |  |                                   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br><b>6 SUNSET LAKE TRAILER PARK</b>  |  |  |  |  |  |  |  | 10f. ZIP CODE<br><b>21811</b>   |  |                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |                                   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>  |  |  |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b>  |  |  |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>HOME</b>   |  |                                   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>CLARENCE CORKRAN</b>   |  |  |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CATHERINE BRIDGES</b>   |  |                                   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>EDWARD PRESTON BURTON</b>   |  |  |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6 SUNSET LAKE TRAILER PARK, BERLIN, MD 21811</b>  |  |                                   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>TRINITY LUTHERAN CEM.</b>   |  |  |  | 20c. LOCATION — City or Town, State<br><b>JOPPA, MD</b>   |  |                                   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  |  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HASTINGS FUNERAL HOME<br/>SELBYVILLE, DELAWARE 19975</b>   |  |                                   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Metastatic Breast Cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  |  |   |  |                                   |  | Approximate Interval Between Onset and Death<br><b>10 years</b>   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>   |  |  |  |  |  |  |  |   |  |                                   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |                                   |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>                  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED |  |   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |                                   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |   |  |                                   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  |  |  |  |  | 29c. LICENSE NUMBER<br><b>030690</b>  |  |                                   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/20/90</b>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>James E. Martin M.D., 1450 Carroll St., Salisbury, MD.</b>   |  |  |  |  |  |  |  |   |  |                                   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 21 '90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |   |  |                                   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Joseph Gorman Brown</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH <i>03</i> DAY <i>16</i> YEAR <i>90</i>  |  | 3. TIME OF DEATH<br><i>2:40 P M</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>217-42-3662</i>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>88</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>6-9-1901</i>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Washington D.C.</i>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>7951 Old Receiver Road</i>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Frederick</i>  |  |
| 9c. COUNTY OF DEATH<br><i>Frederick</i>  |  |  |  | 10a. STATE<br><i>Maryland</i>   |  | 10b. COUNTY<br><i>Prince George</i>  |  |
| 10c. CITY, TOWN OR LOCATION<br><i>Greenbelt</i>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><i>9300 Edmonston Rd. Apt. #204</i>  |  |
| 10f. ZIP CODE<br><i>20770</i>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>White</i>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><i>10 years</i>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Clerical Supervisor</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Government</i>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Joseph Morgan Brown</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Mary Louise Gorman</i>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Margaret B. Ledwith</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>9725 Muckirk Rd. Apt. C48 Laurel, Md. 20708</i>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Fort Lincoln Cemetery</i>  |  | 20c. LOCATION — City or Town, State<br><i>Brentwood, Maryland</i>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Donald V. Borgwardt</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Borgwardt Funeral Home<br/>4400 Powder Mill Rd. Beltsville, Md. 20705</i>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Metastatic Malignant Fibrous Histiocytoma</i>   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Andrew Zarick, Jr. MD</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>D35164</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>3-16-90</i>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Andrew Zarick, Jr. MD 15 E. Frederick St. Wallersville, MD 21793</i>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>MAR 20 1990</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>James Harrison Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

21203-3146

BALTIMORE

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Sara Rea Bur Kom</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>19</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>8:15 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-28-5146</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>92</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>4/11/1897</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Fernwood Nursing Home</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Bethesda</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Bethesda</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>8525 Pelham Road</b>  |  |
| 10f. ZIP CODE<br><b>20817</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>College</b>   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Salesperson</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Rosendorf-Evans Furrier</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Samuel Friedman</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rachael (Unobtainable)</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Hessa Broder (daughter)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8600 Ewing Drive, Bethesda, MD 20817</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>King David Memorial Garden</b>   |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>Falls Church, Virginia</b>  |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br/>1170 Rockville Pike, Rockville, MD 20852</b>   |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acute CVA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Insulin dependant Diabetes</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. Hypertension</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d. Atherosclerotic disease &amp; thrombotic infarction of distal foot</b><br>Approximate Interval Between Onset and Death: <b>3 wks.</b> |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  |  |  | 28b. TIME OF INJURY<br>M <b>1</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>S. Sudhakar, M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D35792</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-19-90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>S. SUDHAKAR, 50 W. EDMONSTON DR, #504, ROCKVILLE</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 20 '90</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Guthrie Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MAR 3-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Virginia Dare Baker</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH <i>3</i> DAY <i>15</i> YEAR <i>90</i>  |  | 3. TIME OF DEATH<br><i>11:32 PM</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>226-09-9800</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>80</i> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>9/23/09</i>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Virginia</i>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Marlboro Grow Medical Ctr</i>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Andrews AFB</i>  |  |
| 9c. COUNTY OF DEATH<br><i>LG</i>   |  |  |  | 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Montgomery</i>   |  |
| 10c. CITY, TOWN OR LOCATION<br><i>Rockville</i>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><i>715 Anderson Avenue</i>   |  |
| 10f. ZIP CODE<br><i>20850</i>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>White</i>   |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><i>12</i>   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Homemaker</i>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Home</i>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Joseph Halterman</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Not available</i>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Marsha L. Pruitt</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>4101 Stratton Rd. Temple Hills, Md 20748</i>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Cheltenham Cemetery</i>   |  |  |  |
| 20c. LOCATION — City or Town, State<br><i>Cheltenham, Md</i>   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>J. Aaron Dyer</i> M00853   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><i>Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805</i>   |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiopulmonary Arrest</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><i>Hypertensive Arterio Sclerosis Cardiovascular Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><br>28b. TIME OF INJURY<br><br>28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>28d. DESCRIBE HOW INJURY OCCURRED<br><br>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><br>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Linda Whitney MD</i>   |  |  |  |
| 29c. LICENSE NUMBER<br><i>D17162</i>   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>3/16/90</i>  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Linda Whitney MD 9556 CRAIN Hwy upper marlboro MD 20772</i>  |  |  |  | 31. DATE FILED (Month, Day, Year)<br><i>MAR 19 '90</i>   |  |  |  |
| 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |  |  |  |  |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital. Page 5 should be detached and filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mary C. Brennan</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 - 14 - 90</b>  |  | 3. TIME OF DEATH<br><b>0240 M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>579-48-9719</b>   |  | 5. SEX<br><b>1</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>1-31-05</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Carroll Manor</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hyattsville</b>   |  | 9c. COUNTY OF DEATH<br><b>Prince Georges</b>   |  |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>PRINCE GEORGE</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>TAKOMA PARK</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>1050 LINDEN AVENUE</b>   |  |   |  | 10f. ZIP CODE<br><b>20912</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>BOOKKEEPER</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>BOOKKEEPER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>CATHOLIC CHARITIES</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>PATRICK WALSH</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARGARET MALONE</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>WINIFRED GERAGHTY (SISTER)</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7417 WILDWOOD DRIVE TAKOMA PARK, MARYLAND 20912</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>METROPOLITAN CREMATORY</b>   |  | 20c. LOCATION — City or Town, State<br><b>ALEXANDRIA, VIRGINIA</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert H. Maloney</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W. SIL SPR., MD 20901</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ACUTE BILATERAL LOWER LOBE PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. CHRONIC ASPIRATION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. Cerebrovascular disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>1 WK</b><br><b>3 MONTHS</b><br><b>YEARS</b><br><b>YEARS</b>                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CONGESTIVE HEART FAILURE</b>   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|   |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Marta Anne Schneider MD</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D-26331</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/14/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARTA ANNE SCHNEIDER MD 5401 MACARTHUR BLVD NW WASH DC 20016</b>  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 16 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randell</b>  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be completed by the attending physician, or attending physician, for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |   |
|--|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARGUERITE L. BAUSCH</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>MARCH</b> DAY <b>11</b> , YEAR <b>1990</b>   |  | 3. TIME OF DEATH<br><b>5:10 A.M.</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>213-74-4906</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>96</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>DEC. 30, 1893</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>OHIO</b>                          |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>14000 LONDON LANE</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ROCKVILLE</b>   |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |   |
| 10a. STATE<br><b>MARYLAND</b>  |  |   |  | 10b. COUNTY<br><b>MONTGOMERY</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>ROCKVILLE</b>                                  |   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br><b>14000 LONDON LANE</b>  |  |  |   |
| 10f. ZIP CODE<br><b>20853</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>          |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b><br>College (1-4 or 5+) <b>HOMEMAKER</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>STEPHEN LEAHY</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ELIZABETH FLAHERTY</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARY M. BAUSCH (DAUGHTER)</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14000 LONDON LANE, ROCKVILLE, MARYLAND 20853</b>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GATE OF HEAVEN CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>SILVER SPRING, MARYLAND</b>   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James E. Dooley</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W., SIL. SP., MD 20901</b>   |  |   |  |  |   |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>DEHYDRATION</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>GASTRITIS, SUBACUTE</b><br><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Jonathan Plotky MD</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>D38589</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>MARCH 12, 1990</b>                     |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JONATHAN PLOTSKY MD 12102 GEORGIA AVENUE WHEATON</b>   |  |   |  |   |  |  |   |
| 31. DATE FILED<br><b>MAR 16 90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>James E. Dooley</i>   |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21211-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained for the funeral director. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

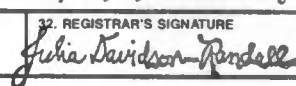
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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FRANCES REBECCA BLUM</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>03</b> DAY <b>14</b> YEAR <b>1990</b>  |  | 3. TIME OF DEATH<br><b>8:40 A. M.</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>100-12-4286</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>66</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>May 18, 1923</b>                                      |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>New York</b>   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>202 Fleece Flower Drive</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Gaithersburg</b>  |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |   |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Rockville</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>1008 Welch Drive</b>   |  |  |  | 10f. ZIP CODE<br><b>20852</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>David Finebaum</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ester Rosenthal</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Jerome Blum</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1008 Welch Dr., Rockville, MD 20852</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Suburban Crematory</b>  |  | 20c. LOCATION — City or Town, State<br><b>Silver Spring, MD</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br> <b>MO0827</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Rapp Funeral Services, P.A.<br/>933 Gist Avenue, Silver Spring, MD 20910</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acute myocardial disease.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>None</b>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |   |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br> <b>Deputy Medical Examiner</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D09975</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/14/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John S. Rogers, M.D., 1919 Seminary Road, Silver Spring, MD 20910</b>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 15 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21201

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician. Pages 1, 2, 3 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be retained by the funeral director. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 08802

|  |  |  |  |   |  |  |  |   |   |
|--|--|--|--|---|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>John Edward Powers</b>  |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>02</b> DAY <b>24</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>1253</b> M   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>219-14-9725</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>66</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>JAN 26, 1924</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>PA.</b>  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>FREDERICK MEMORIAL HOSPITAL</b>   |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>FREDERICK MD</b>   |  | 9c. COUNTY OF DEATH<br><b>FREDERICK</b>   |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |   |   |
| 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>FREDERICK</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>THURMONT</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>7209 BLACK RD.</b>  |  |  |  | 10f. ZIP CODE<br><b>21788</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |   |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b> |   |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+) <b>5</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>SELF EMPLOYED</b>   |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>GRAVEDIGGER</b>                       |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>EDWARD BOWERS</b>  |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ELIZABETH LEHN</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ROSEANN ECKEN</b>   |  |  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>RD #6 BOX 670 HANOVER PA 17331</b> |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>EMMITSBURG MEMORIAL</b>  |  |  | 20c. LOCATION — City or Town, State<br><b>EMMITSBURG MD</b>                |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>John M. Shels</b>  |  |  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SKILS FUNERAL HOME, EMMITSBURG MD 21727</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebral Hemorrhage</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
|  |  |  |  |   |  |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Edward P. Powers</b>   |  |  |  |   |  | 29c. LICENSE NUMBER<br><b>MD D36649</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>FEB 26 1990</b>                                       |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>310 W 9th St Frederick MD 21701</b>  |  |  |  |   |  |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 26 1990</b>  |  |  |  |   |  |  |  |   |   |
| 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>   |  |  |  |   |  |  |  |   |   |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Mary Olive Boyer  |  |  |  | 2. DATE OF DEATH<br>FEB. 16, 1990  |  |  |  | 3. TIME OF DEATH<br>9:30 A. M   |  |
| 4. SOCIAL SECURITY NUMBER<br>212-14-7370  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>84 YRS.  |  | 7. DATE OF BIRTH<br>Sept. 29, 1905   |  | 8. BIRTHPLACE (State or Foreign Country)<br>Md.   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Meridian Nursing Center   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick   |  |  |  | 9c. COUNTY OF DEATH<br>Frederick  |  |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |  |  |   |  |
| 10a. STATE<br>Md.   |  | 10b. COUNTY<br>Frederick   |  | 10c. CITY, TOWN OR LOCATION<br>Jefferson   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br>4204 Jefferson Pike   |  |  |  | 10f. ZIP CODE<br>21755   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>homemaker   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>own home   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Theodore Routzahn  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Estie Younkens  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Homer A. Boyer Jr.  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4204 Jefferson Pike, Jefferson, Md. 21755   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Reformed Cemetery  |  | 20c. LOCATION — City or Town, State<br>Middletown, Md.   |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Donald B. Thompson</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Donald B. Thompson Funeral Home<br>31 E. Main St., Middletown, Md. 21755   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiac arrest</i><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br><i>immediate</i>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>hypertension disease</i>   |  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
|   |  |  |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 25. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide  |  | 26a. DATE OF INJURY (Month, Day, Year)   |  | 26b. TIME OF INJURY<br>M   |  | 26c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 26d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Wayne Hagan</i>   |  |  |  | 29c. LICENSE NUMBER<br>016675  |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/20/90                                       |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Waine Aligater, Brunswick, Md. 21716</i>  |  |  |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 21 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |  |  |  |
|---|--|--|--|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mary Ann Byron</b>   |  |  |  |  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>February</b> DAY <b>23</b> YEAR <b>1990</b>  |  |   |  | 3. TIME OF DEATH<br><b>0515</b> M   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-28-7101</b>   |  |  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>55</b> YRS. |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>March 10, 1934</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b> |  |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>  |  |  |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  |   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |  |  |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>Frederick</b>  |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |  |
| 10e. STREET AND NUMBER<br><b>402 Taney Avenue</b>   |  |  |  |  |  |  |  | 10f. ZIP CODE<br><b>21701</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input checked="" type="checkbox"/>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Security Clerk</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U. S. Government</b>   |  |   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Frank W. Yanos</b>  |  |  |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Hazel Suter</b>   |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>William F. Byron</b>   |  |  |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1629 Colombia Rd., N. W., Washington D. C. 20009</b>  |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Olivet Cemetery</b>   |  |  |  | 20c. LOCATION — City or Town, State<br><b>Frederick, Md. 21701</b>  |  |   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Richard C. C. Bayard</i> M00021   |  |  |  |  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney and Basford Funeral Home<br/>106 East Church Street, Frederick, Md. 21701</b>   |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>pulmonary embolism</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>pulmonary hypertension</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>previous RULobectomy Dec 1988 for cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>L.V. Lobectomy for Metastatic solitary cancer 2/22/90</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>(L) Thoracotomy, L.V. Lobectomy for cancer 2/22/90</b> |  |  |  |  |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M                         |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE NOW INJURY OCCURRED                               |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Nicholas P. Foris MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D03666</b>  |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/23/90</b>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>NICHOLAS P. FORIS 915 TOLLHOUSE - 6624010 FICOLENS</b>  |  |  |  |  |  |  |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 26 1990</b>   |  |  |  |  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |   |  |  |  |

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HELEN GERALDINE BOYER</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>15</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>0417</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-38-1198</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>May 27, 1913</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Knoxville</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>1420 Jefferson Pike</b>   |  |  |  | 10f. ZIP CODE<br><b>21758</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>                |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Casper Pfeifer</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lena Gantt</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Carol B. Smith</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3802 Brook Drive, Jefferson, Maryland 21755</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mount Olivet Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Frederick, Maryland</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Kathleen Robinson</i> 000706   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney &amp; Basford PA Funeral Home</b><br><b>106 East Church St., Frederick, MD 21701</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  | Approximate interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus</b><br><b>Coronary atherosclerosis</b>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 28g. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Austin A. Pearre, Jr.</i>  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/15/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Austin A. Pearre, Jr., MD 300 West Ninth St., Frederick, Maryland 21701</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 16 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Francis Willson Bush Sr.</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH <i>02</i> DAY <i>14</i> YEAR <i>90</i>  |  | 3. TIME OF DEATH<br><i>0045</i> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>217-18-5933</i>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>70</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>10-21-12</i>   |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><i>Northampton Manor</i>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Frederick</i>   |  | 9c. COUNTY OF DEATH<br><i>Frederick</i>   |  |
| 10a. STATE<br><i>Maryland</i>   |  |  |  | 10b. COUNTY<br><i>Frederick</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>Walkersville</i>  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><i>9910 Greenbrier Lane</i>   |  |   |  |
| 10f. ZIP CODE<br><i>21793</i>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>                               |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Personnel Director</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Gem-Star</i>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Charles D. Bush</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Florence Willson Bush</i>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Marian Bush</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>9910 Greenbrier Lane, Walkersville, MD 21701</i>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Smithsburg Crematory</i>  |  | 20c. LOCATION — City or Town, State   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Sharon Camille Clive</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Stauffer Funeral Homes, P.A.<br/>P.O. Box 1819, Frederick, MD 21701</i>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Thoracic Aneurysm</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>Arteriosclerotic vascular disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  | Approximate Interval Between Onset and Death<br><i>2 mos</i><br><i>5 years</i>                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Alzheimer's Disease</i>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO           |  |
| 28d. DESCRIBE HOW INJURY OCCURED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Le Roy T. Davis</i>  |  | 29c. LICENSE NUMBER<br><i>DO 1902</i>   |  | 29d. DATE SIGNED (Month/Day/Year)<br><i>2/15/90</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>FEB 15 1990</i>   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

11:25 a.m.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Edgar E. Biddinger</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>02</b> DAY <b>02</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>11:25 A.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-10-0866</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>04/08/17</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Shady Grove Adventist Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Damascus</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>10025 Locust Drive</b>  |  |
| 10f. ZIP CODE<br><b>20872</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>American</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Caretaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Montgomery County Agricultural Society</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>David Biddinger</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Nina Boone</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Margaret N. Biddinger</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10025 Locust Dr., Damascus, Md. 20872</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Union Chapel Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Libertytown, Md.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert L. Williams</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Olin L. Molesworth, P.A., Funeral Home<br/>Damascus, Maryland 20872</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>VENTRICULAR ARRHYTHMIA</b>   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| a. <b>CHRONIC SCHOEN</b>  |  |  |  |   |  |  |  |
| b. <b>RESPIRATORY DISTRESS</b>  |  |  |  |   |  |  |  |
| c. <b>ISCHEMIC CARDIOMYOPATHY</b>   |  |  |  |   |  |  |  |
| d. <b>ISCHEMIC CARDIOMYOPATHY</b>   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ACUTE PANCREATITIS</b><br><b>CONGESTIVE HEART FAILURE</b>  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |  |  |   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  |  |  |   |  |  |  |
| 28b. TIME OF INJURY<br><b>M</b>   |  |  |  |   |  |  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Gregg R. Koff</b>   |  |  |  |   |  |  |  |
| 29c. LICENSE NUMBER<br><b>DI 6145</b>   |  |  |  |   |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>212/1990</b>  |  |  |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>GREGG R. KOFF 15255 SHADY GROVE RD. ROCKVILLE</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 05 1990</b>   |  |  |  |   |  |  |  |
| 32. REGISTRAR'S SIGNATURE<br><b>Julia B. [Signature]</b>  |  |  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>Doris E. Burdette</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 8, 1990</b>  |  | 3. TIME OF DEATH<br><b>7:16 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-58-7497</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Nov. 13, 1916</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Montgomery General Hospital</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Olney</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |  |
| 10a. STATE<br><b>Maryland</b>   |  |   |  | 10b. COUNTY<br><b>Montgomery</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Gaithersburg</b>   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>23720 Woodfield Road</b>   |  |   |  | 10f. ZIP CODE<br><b>20882</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b><br>College (1-4 or 5+) <b>Housewife</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Grover M. Stanley</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rosa L. Boyer</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>John G. Burdette</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>23720 Woodfield Rd., Gaithersburg, Md. 20882</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Wesley Grove Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Woodfield, Md.</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Olin L. Molesworth</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Olin L. Molesworth, P.A.<br/>26401 Ridge Rd., Damascus, Md. 20872</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>dilated cardiomyopathy</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>2 chronic sclerotic heart disease</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>months</b><br><b>7 YEARS</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>RENAL failure</b><br><b>diabetes mellitus</b>  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dr. Tannenbaum</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>B5017328</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/8/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Tannenbaum, M.D. 10401 Old Georgetown Rd. Bethesda, MD 20814</b>  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 10 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rendell</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3, 4, and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Emily Pickett Brown</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>8</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>1:21 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-36-8759</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Nov. 15, 1904</b>                                  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>  |  |
| 10a. STATE<br><b>Maryland</b>   |  |   |  | 10b. COUNTY<br><b>Howard</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Woodbine</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br><b>1471 St. Michael's Road</b>  |  |  |  |
| 10f. ZIP CODE<br><b>21797</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                      |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Teacher</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Public Schools</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Matthew Pickett</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Bessie Mullinix</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Merhlyn Barnes</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1878 Rt. 94, Woodbine, Md. 21797</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Poplar Springs Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Poplar Springs, Md.</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Olin L. Molesworth</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Olin L. Molesworth, P.A.<br/>26101 Ridge Rd., Damascus, Md. 20872</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ventricular Fibrillation</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. <b>Myocardial Infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Coronary artery disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |  | Approximate Interval Between Onset and Death<br><b>minutes</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive heart failure</b><br><b>Diabetes</b><br><b>Renal Insufficiency</b>  |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                 |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Ali J. A. Fracktel MD</b>  |
| 29c. LICENSE NUMBER<br><b>D 35183</b>   |  |   |  |   |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/8/90</b>   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Ali J. A. Fracktel 300 W 9th St, Frederick, MD</b>  |  |   |  |   |  |  | 31. DATE FILED (Month, Day, Year)<br><b>JAN 10 1990</b>  |
| 32. REGISTRAR'S SIGNATURE<br><b>Johanna Davidson-Randall</b>  |  |   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>GERALD WILLIAM BEVERIDGE  |  |  |  | 2. DATE OF DEATH<br>MONTH 1 DAY 20 YEAR 90  |  | 3. TIME OF DEATH<br>0910 M  |  |
| 4. SOCIAL SECURITY NUMBER<br>059-14-1461  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>70 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>6-17-1919  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Frederick Memorial Hospital   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick  |  | 9c. COUNTY OF DEATH<br>Frederick  |  |
| 10a. STATE<br>Maryland  |  |  |  | 10b. COUNTY<br>Frederick  |  | 10c. CITY, TOWN OR LOCATION<br>Frederick  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br>635 Grant Place   |  |   |  |
| 10f. ZIP CODE<br>21701  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                            |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Information Specialist  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>U.S. Government   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Gerald Paul Beveridge  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Anna Greenbaum   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Donald R. Beveridge   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1754 Springfield Lane Frederick, Md. 21701   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mount Olivet Cemetery  |  | 20c. LOCATION — City or Town, State<br>Frederick, Maryland  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert E. Dailey</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.<br>1201 North Market Street Frederick, Md 21701  |  |   |  |
| 23. PART I—Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>respiratory and renal failure</i><br><i>preparation of colon with</i><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><i>Peritonitis and Gangrene</i><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><i>Colon carcinoma</i><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>ASCUD, S/P CTSG</i>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |   |  |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>P. Gregory Rausch</i>   |  |  |  | 29c. LICENSE NUMBER<br>P14624   |  | 29d. DATE SIGNED (Month, Day, Year)<br>1/20/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>P. Gregory Rausch, M.D. West 7th Street Frederick, Md..21701   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>JAN 22 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John L. ...</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 08811

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Thomas Edward Pickett BARBOUR  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>January 5, 1990   |  | 3. TIME OF DEATH<br>3:20 p M   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>578-52-9553   |  | 5. SEX<br>XX M 2 F                        |  | 6. AGE (In yrs. last birthday)<br>88 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Jan. 24, 1901  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Meridian Nursing Center  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick  |  | 9c. COUNTY OF DEATH<br>Frederick   |  |   |  |
| 10a. STATE<br>Pennsylvania   |  |   |  | 10b. COUNTY<br>Cumberland   |  | 10c. CITY, TOWN OR LOCATION<br>Camp Hill   |  |   |  |
| 10d. INSIDE CITY LIMITS?<br>1 X YES 2 F NO   |  |   |  | 10e. STREET AND NUMBER<br>2300 Market Street  |  | 10f. ZIP CODE<br>17011   |  |   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  | 11. MARITAL STATUS<br>1 F Never Married 2 F Married<br>3 X Widowed 4 F Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 X YES 2 F NO<br>IF YES, GIVE WAR OR DATES<br>6/12/1926-7/31/1954          |  |   |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 F YES 2 X NO Specify:   |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4 |  |   |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Army Colonel  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>United States Government  |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>George Taylor Barbour   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Margaret Abby Pickett  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Helen J. Myers  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2300 Market Street, Camp Hill, Pennsylvania 17011  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 F Burial 2 X Cremation 3 F Removal from State<br>4 F Donation 5 F Other (Specify)  |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Smithsburg Crematory  |  | 20c. LOCATION — City or Town, State<br>Smithsburg, Maryland  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Kath Lynn Robinson</i> M00706  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Keeney & Basford PA Funeral Home<br>106 East Church St., Frederick, MD 21701  |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Pneumonia</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b.<br>c.<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>MULTIPLE DEBRITI ECALULITIS</u><br><u>SEVERE DENGITIA</u><br><u>BILAT CVD</u> |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 F YES 2 X NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 F YES 2 F NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 F YES 2 X NO   |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 F Inpatient 2 F ER/Outpatient 3 F DOA<br>OTHER: 4 X Nursing Home 5 F Residence 6 F Other (Specify)   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 X Natural 5 F Pending Investigation<br>2 F Accident 6 F Could not be determined<br>3 F Suicide 4 F Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year) |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 F YES 2 F NO   |  |   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  | 29a. CERTIFIER<br>(Check only one)<br>XX CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 F MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Richard Gough</i>  |  |   |  | 29c. LICENSE NUMBER<br>D32171   |  | 29d. DATE SIGNED (Month, Day, Year)<br>1/8/90  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Richard Gough, MD, 19 West Frederick Street, Walkersville, Maryland 21793   |  |   |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>JAN 08 1990   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Alexander George Brown</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>1 17 90</i>  |  | 3. TIME OF DEATH<br><i>12:42 P.M.</i>   |   |
| 4. SOCIAL SECURITY NUMBER<br><i>157-10-3331</i>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>83</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>July 14, 1906</i>                                  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Ireland</i>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Frederick Memorial Hospital</i>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Frederick</i>   |   |
| 9c. COUNTY OF DEATH<br><i>Frederick</i>   |  |  |  | RESIDENCE OF DECEDENT   |  |   |   |
| 10a. STATE<br><i>Maryland</i>   |  | 10b. COUNTY<br><i>Frederick</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>Walkersville</i>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><i>300 Chapel Court</i>   |  |  |  | 10f. ZIP CODE<br><i>21793</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>White</i>                      |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><i>Elementary/Secondary (0-12)</i><br><i>12</i>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Milk Delivery</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Sealtest Dairy</i>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Samuel Brown</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Mary Jane Fannin</i>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Mrs. Elizabeth Kiernan Brown</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>300 Chapel Court, Walkersville, Maryland 21793</i>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Hollywood Memorial Park</i>   |  | 20c. LOCATION — City or Town, State<br><i>Union, New Jersey</i>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert K. Anderson</i> M00706   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Keeney &amp; Basford PA Funeral Home</i><br><i>106 East Church St., Frederick, MD 21701</i>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiopulmonary Arrest</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <i>Ischemic Heart Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Coronary Artery Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Edward P. Kunkin MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><i>MD 036649</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>1/17/90</i>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br><i>310 West 9th St Frederick MD 21701</i>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><i>JAN 19 1990</i> REGISTRAR'S SIGNATURE<br><i>John Davidson Anderson</i>  |  |  |  |   |  |   |   |

COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be used for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |   |   |
|---|--|---|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>David Carlos Braswell   |  |   |  | 2. DATE OF DEATH<br>MONTH 3 DAY 3 YEAR 90  |  | 3. TIME OF DEATH<br>12:19 A. M  |   |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>24 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>12/7/'65   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Southern Maryland Hospital  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Clinton   |  | 9c. COUNTY OF DEATH<br>Prince George's  |   |
| 10a. STATE<br>Maryland  |  |   |  | 10b. COUNTY<br>Charles   |  | 10c. CITY, TOWN OR LOCATION<br>Malcolm  |   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br>Route 1 Box 35   |  | 10f. ZIP CODE<br>20613  |   |
| 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |   |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black   |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th<br>College (1-4 or 5+) College (1-4 or 5+)   |  | 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>unemployed                       |  | 17. KIND OF BUSINESS/INDUSTRY   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>George Samuel Estep  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Henrietta Braswell  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Henrietta Braswell  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Rte. 1 Box 35, Brandywine, MD 20613             |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>St. Peter's Church Cem.   |  | 20c. LOCATION — City or Town, State<br>Waldorf, Maryland   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Martell Adams  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Adams Funeral Home<br>Aquasco Road, Aquasco, MD 20608  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gunshot Wounds to Front of Abdomen and back of Right Chest<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |  |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |  |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |   |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>3-2-90  |  | 28b. TIME OF INJURY<br>10:57P  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |   |
| 28d. DESCRIBE HOW INJURY OCCURRED<br>subject was shot   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>front of Birdland Bar   |  |  |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>Horsehead Rd., Charles Co., Md.   |  |   |  |  |  |   |   |
| 29a. CERTIFIER (Check only)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Julia C. Goodin, M.D.  |  |   |  | 29c. LICENSE NUMBER<br>OCME  |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-3-90   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Julia C. Goodin, M.D. 111 Penn St., Balto., Md. 21201  |  |   |  |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>MAR 16 '90   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Braswell  |  |  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Robert Maurice Boulter</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 13 90</b>   |  | 3. TIME OF DEATH<br>M<br><b>M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-16-9573</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><b>81</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>05-10-08</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Kent-Queen Anne's Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Chestertown</b>   |  | 9c. COUNTY OF DEATH<br><b>Kent</b>  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Kent</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Rock Hall</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>Rt. 1 Box 75 Skinners Neck</b>   |  |  |  | 10f. ZIP CODE<br><b>21661</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b><br>College (1-4 or 5+) <b>Waterman</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Seafood</b>              |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Edwin Boulter</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sadie Elizabeth Grulkey</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Leona E. Kendall</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Rt. 1 Box 82, Rock Hall, MD 21661</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Wesley Chapel Cemetery</b>                                      |  | 20c. LOCATION — City or Town, State<br><b>Rock Hall, MD (Kent)</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Thomas R. Helfenbein</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Tom Helfenbein Funeral Homes, PA<br/>Rock Hall, MD 21661</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. metabolic acidosis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. probable metastatic prostate cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d. Severe Cachexia/malnutrition</b> |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>N/A</b>   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>David Shulman M.D.</i>   |  | 29c. LICENSE NUMBER<br><b>D 36064</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/15/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Barrie J. Stansbury 574 WOOD AVE CHESTERTOWN 21620</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 15 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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REG. NO.

DMMH-18 Rev 1/89

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>John T Bossert</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 6 1990</b>  |  | 3. TIME OF DEATH<br><b>4.35 A M</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>212-07-1571</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11 10 09</b>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>PA</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Memorial Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Easton</b>   |   |
| 9c. COUNTY OF DEATH<br><b>Talbot</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Talbot</b>   |   |
| 10c. CITY, TOWN OR LOCATION<br><b>Easton</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>407 Trippe Avenue</b>   |   |
| 10f. ZIP CODE<br><b>21601</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (14 or 5+) <b>5+</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>realtor associate</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>real estate</b>   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Clifford Hamilton Bossert</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ella McKannar</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ann B. Bossert</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>407 Trippe Avenue, Easton, MD 21601</b>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>New Cathedral Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>M.E. Newnam M CFSR</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Newnam Funeral Home<br/>Easton, MD 21601</b>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>Disseminated Intravascular Coagulation</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Septicemia</b><br><b>Aspiration Pneumonia</b> |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>48h</b><br><b>8d</b><br><b>8d</b>                  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ASCVD &amp; Coronary Artery Disease</b>   |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |   |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Donald T. Lewers M.D.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D05874</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/6/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Donald T. Lewers, M.D. Easton, MD 21601</b>  |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 08 '90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson Randall</b>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SAMUEL K. BRITT</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 14 1990</b>  |  | 3. TIME OF DEATH<br><b>P M</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>237-28-6641</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 5, 1911</b>                                     |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>North Carolina</b>   |  |   |  |   |  |   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>570 Bellerive Drive</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Annapolis</b>   |  | 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>  |   |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Anne Arundel</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Annapolis</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>570 Bellerive Drive</b>  |  |   |  | 10f. ZIP CODE<br><b>21401</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>Security Guard</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Security Guard</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Private</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Arthur Britt</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Angeline Barnes</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lydia Cain Britt</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>570 Bellerive Drive, Annapolis, MD 21401</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Hillcrest Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Annapolis, MD</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Jeffrey S. Taylor</i>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Taylor Funeral Chapel 21401<br/>147 Gloucester St., Annapolis, MD</b>  |  |   |  |   |   |
| 23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Squamous cell Carcinoma</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br><b>14 mos</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>COPD<br/>Myocardial Infarction</b>   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |   |  |   |   |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Margaret M. Mullins, MD</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>D 26375</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/15/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Margaret Mullins, M.D. 586 Bellrive Drive, Suite 2-B, Annapolis, MD</b>   |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 16 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Sonia Davidson-Randall</i>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21201-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be completed as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO: [illegible] FROM: [illegible] DATE: [illegible]

SUBJECT: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

17. [illegible]

18. [illegible]

19. [illegible]

20. [illegible]

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>AGNES M BLODGETT</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> - DAY <b>2</b> - YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>5:55 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-12-6840</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug 15, 1902</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>IVY HALL GERIATRIC CENTER</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |  |  | RESIDENCE OF DECEDENT   |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>BALTIMORE</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>117 Mopac Circle</b>  |  |  |  | 10f. ZIP CODE<br><b>21221</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>CAUCASIAN</b>                      |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (14 or 5+) <b>0</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Housekeeping</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Calhoun Nicholson</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Blanche Nicholson</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Louis A. Blodgett</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>117 Mopac Circle Baltimore Md 21221</b>   |  |   |  |
| 20. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Zion Church Cem</b>   |  | 20c. LOCATION — City or Town, State<br><b>Madison Co. Virginia</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Joseph W. Preddy</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>#040 PREDDY FUNERAL HOME<br/>250 W. MAIN ST. ORANGE VA 22960</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>CARDIOVASCULAR ARREST</b>  |  |   |  |   |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  | b. <b>RA-PHAGY CUP. DEMENTIA. SKIN LES.</b>  |  |   |  |   |  |
|  |  | c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | e. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John L. ...</b>  |  | 29c. LICENSE NUMBER<br><b>D-14221</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3.2.1990</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>223 E. Blvd BALTIMORE MD 21221</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 26 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson Randall</b>  |  |   |  |   |  |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



James M. [illegible]

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Malin A. Banks, Sr.   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3/23/90   |  | 3. TIME OF DEATH<br>9:45 AM  |  |
| 4. SOCIAL SECURITY NUMBER<br>218-14-2356  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>66 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>2-7-24                                     |  |
| 8. FACILITY NAME (If not institution, give street and number)<br>Union Hospital   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Elkton   |  | 9c. COUNTY OF DEATH<br>Cecil   |  |
| 10a. STATE<br>Md.   |  |  |  | 10b. COUNTY<br>Cecil  |  | 10c. CITY, TOWN OR LOCATION<br>Elkton  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>113 South Street  |  |  |  | 10f. ZIP CODE<br>21921  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WW 2  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>9  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Weigh-Master  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Cecil Co. Landfill  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Cornell E. Banks   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Marie Lloyd  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mary Jane Banks   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>113 South Street, Elkton, Md. 21921  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Elkton Cemetery  |  | 20c. LOCATION — City or Town, State<br>Elkton, Md.  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Gee Funeral Home 259 E. Main St.,<br>Elkton, Md. 21921  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Malignant astrocytoma<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br>5 mo.  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
|   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Henry Farkas, MD   |  |  |  | 29c. LICENSE NUMBER<br>D15314   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3/23/90                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Henry Farkas, M.D. Northern Chesapeake Hospice, Elkton, MD   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 26 '90   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 1314, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |                                 |  |  |  |  |  |
|--|--|---------------------------------|--|--|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>JAMES A. BEST JR.</b>   |  |                                 |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>7</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>232 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>244-12-6184</b>  |  | 5. SEX<br><b>1</b> M <b>2</b> F |  | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>3-6-17</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>N. CAROLINA</b>   |  |                                 |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>ST. AGNES HOSPITAL</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>  |  |
| 9c. COUNTY OF DEATH  |  |                                 |  | 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>HOWARD</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>ELLICOTT CITY</b>  |  |                                 |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> YES <b>2</b> NO   |  | 10e. STREET AND NUMBER<br><b>3902 ST. JOHN'S LANE</b>  |  |
| 10f. ZIP CODE<br><b>21043</b>  |  |                                 |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br><b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced |  |
| 12. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO<br>IF YES, GIVE WAR OR DATES  |  |                                 |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> YES <b>2</b> NO                                      |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                       |  |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  |                                 |  | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>REGIONAL MANGER MONTGOMERY WARDS</b>                            |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JAMES A. BEST</b>  |  |                                 |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>DEES</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MAE BEST</b>  |  |                                 |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3902 ST. JOHN'S LANE ELLICOTT CITY MD 21043</b>                              |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)  |  |                                 |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CRESTLAWN</b>   |  | 20c. LOCATION — City or Town, State<br><b>MARRIOTTSTVILLE MD</b>                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Harry H. Witke</b>   |  |                                 |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HARRY H. WITKE FUNERAL HOME<br/>4112 COLUMBIA PIKE<br/>ELLICOTT CITY MD 21043</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Laryngeal CA c Metastases</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>Renal Failure</b><br><b>Cardiac Arrhythmia</b> |  |                                 |  |  |  |  | Approximate Interval Between Onset and Death               |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                                 |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> YES <b>2</b> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> YES <b>2</b> NO  |  |                                 |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> YES <b>2</b> NO   |  |                                 |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA OTHER: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide <b>5</b> Pending Investigation <b>6</b> Could not be determined   |  |                                 |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><b>1</b> YES <b>2</b> NO   |  |                                 |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                     |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |                                 |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>  |  |                                 |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/7/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>1900 Cedar Ave Balt MD</b>   |  |                                 |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 09 '90</b>   |  |                                 |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Richard D. Blankenship</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 2, 1990</b>  |  | 3. TIME OF DEATH<br>M<br><b>8:pm</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>213 42 9225</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>46</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>February 20 '44</b>  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>6636 lot 51 Washington Boulevard</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Elkridge</b>   |   |
| 9c. COUNTY OF DEATH<br><b>Howard</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Howard</b>   |   |
| 10c. CITY, TOWN OR LOCATION<br><b>Elkridge</b>   |  |  |  | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>6636 lot 51 Washington Boulevard</b>  |   |
| 10f. ZIP CODE<br><b>21227</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Installer</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Dry Wall</b>  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Dawdie Blankenship</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lessy</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs Carolyn Blankenship</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6636 lot 51 Washington Blvd. 21227</b>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Union Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Maryland<br/>Burtonsville Montgomery</b>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Harry H. Witzke</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Harry H Witzke Funeral Home Inc<br/>4112 Old Columbia Pike Ellicott City</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>cardiopulmonary arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>metastatic malignant melanoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
|  |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |   |
|  |  |  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE NOW INJURY OCCURRED  |   |
|  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Christian O. Uellewicz</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D23743</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-5-90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARTIN D. WELTZ 1525 Greenway Cir Orme Greenbelt MD</b>  |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 05 '90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b><br><b>20770</b>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


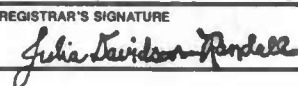
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 08822

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LORNA MAE BLAIR</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>MARCH</b> DAY <b>24</b> , 1990 YEAR  |  | 3. TIME OF DEATH<br><b>11:30 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>196-24-0499</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>58</b> YRS.  |  | 7. DATE OF BIRTH<br>MONTH <b>NOV.</b> DAY <b>26</b> , 1931  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>9017 HOLLY AVE.</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>WALDORF</b>   |  | 9c. COUNTY OF DEATH<br><b>CHARLES</b>   |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |   |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>CHARLES</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>WALDORF</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>9017 Holly Avenue</b>  |  |   |  | 10f. ZIP CODE<br><b>20601-3319</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                          |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>George Cooper</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Erma Sadoski</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>William W. Blair</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9017 Holly Ave., Waldorf, Md. 20601-3319</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Huntt Crematory</b>  |  | 20c. LOCATION — City or Town, State<br><b>Waldorf, Md.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Huntt Funeral Home<br/>P. O. Box 156, Waldorf, Md. 20604-0156</b>  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arteriosclerotic Cardiovascular disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br><b>few</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
|   |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  |   |  |
|   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Huntt M O Chas G M E</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>D27348</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>26 March 1990</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J. M. Huntt MD 3456 Tanavack Ct Waldorf Md 20601</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 27 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

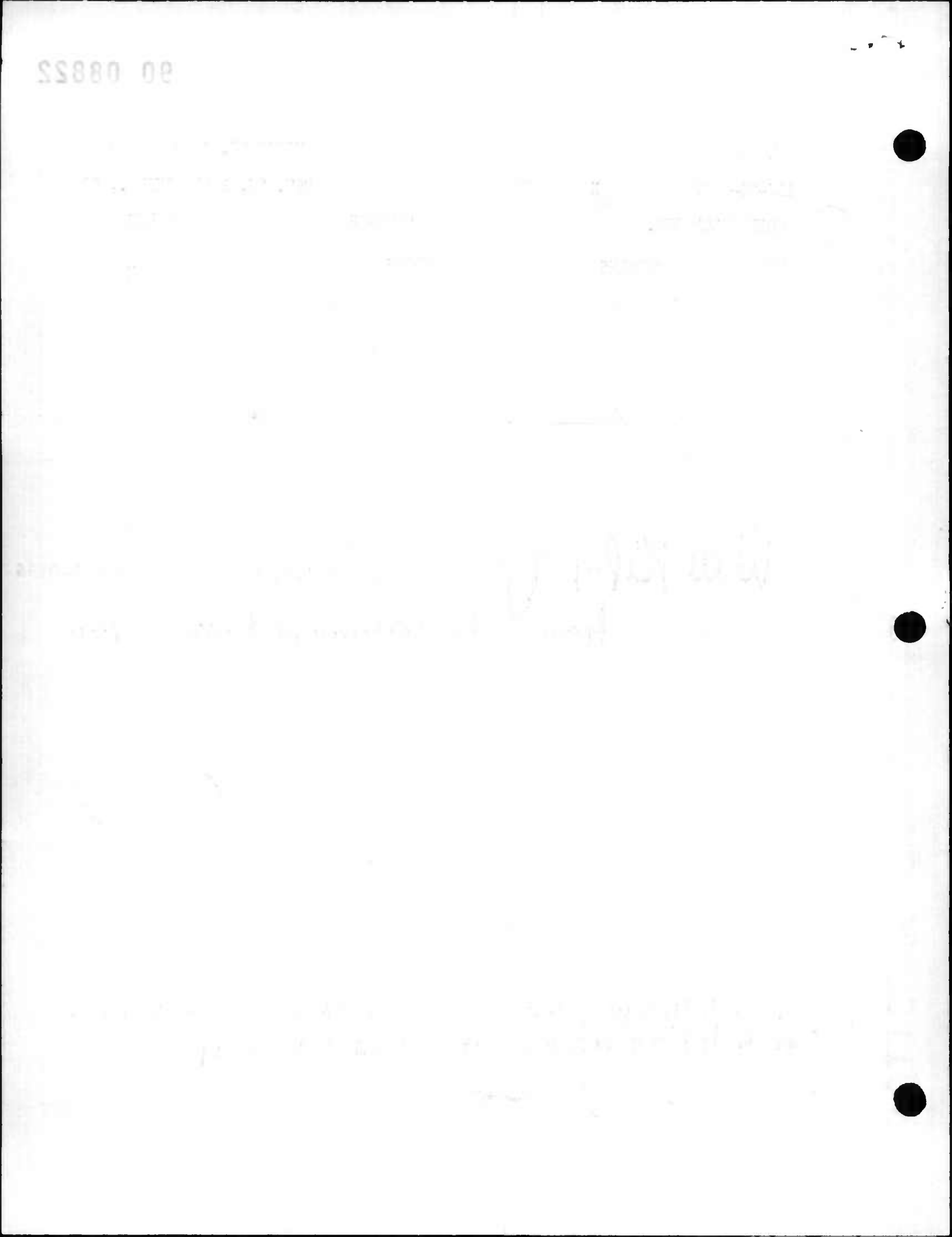
BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>POWERS, EFFIE IRENE</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 19 90</b>  |  | 3. TIME OF DEATH<br><b>0100</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-28-5299</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (in yrs. last birthday)<br><b>76</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 6, 1913</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Washington County Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>  |  | 9c. COUNTY OF DEATH<br><b>Washington</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY<br><b>Washington</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>Rfd. 1 Box 358</b>  |  |  |  | 10f. ZIP CODE<br><b>21740</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>6</b> College (1-4 or 5+) <b>6</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Finisher</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Clothing Mfg.</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles L. Biser</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary V. Lapole</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Helen Monn</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Rfd. 1 Hagerstown, Md. 21740</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Beaver Creek Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Beaver Creek, Md.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>John H. Bast, Jr.</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>7606 Boonsboro Pike<br/>BAST FUNERAL HOME, Boonsboro, Md. 21713</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Myocardial Failure</b><br>Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Coronary Artery Disease with Myocardial Infarction</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>Days</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
|  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Gloria F. Pura M.D.</b>  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/19/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Gloria F. Pura M.D. 366 Mill St, Hagerstown, Maryland 21740</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 19 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Lelia Davidson-Randall</b>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |   |
|--|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Anna C. Burger   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Mar. 11 1990  |  | 3. TIME OF DEATH<br>12:15A M   |   |
| 4. SOCIAL SECURITY NUMBER<br>214-09-6741   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>84 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>May 10, 1905                               |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Pennsylvania   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>219 S. North Street   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Maugansville   |  | 9c. COUNTY OF DEATH<br>Washington  |   |
| 10a. STATE<br>Maryland   |  |   |  | 10b. COUNTY<br>Washington   |  | 10c. CITY, TOWN OR LOCATION<br>Maugansville  |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br>219 S. North Street   |  |  |   |
| 10f. ZIP CODE<br>21767   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: white                     |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) 8 College (1-4 or 5+) 8  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>housewife  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>own home  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>William M. Spangler   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Emma K. Wiles  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Viola M. Manspeaker   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>219 S. North Street Maugansville, MD 21767   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Rest Haven Cemetery   |  | 20c. LOCATION — City or Town, State<br>Hagerstown, MD   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Minnich-Miller-May Funeral Home<br>112 E. Baltimore Street Greencastle, PA 17225  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardio Pulmonary Arrest<br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. Congestive Heart Failure<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Left Ventricular Hypertrophy<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. Hypertension<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Other (Specify)   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Jay Bayer, DO   |  |   |  | 29c. LICENSE NUMBER<br>05002807-L   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3/12/90                                       |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Jay Bayer, DO 17 W. Baltimore St., Greencastle, Pa 17225  |  |   |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>MAR 15 '90  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randell   |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>John Francis Boyle</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 23, 1990</b>   |  | 3. TIME OF DEATH<br><b>11:45 PM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>179-24-9528</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug. 21, 1910</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>3416 Manor Road</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Chevy Chase</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |
| 10a. STATE<br><b>MD</b>   |  |  |  | 10b. COUNTY<br><b>Montgomery</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Chevy Chase</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>3416 Manor Road</b>  |  |   |  |
| 10f. ZIP CODE<br><b>20815</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 8+)<br><b>4</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Attorney</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Law Firm</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Boyle</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elizabeth Henler</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary Joyce Murphy</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3308 Winnett Road, Chevy Chase, MD 20815</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Comfort Crematory</b>   |  | 20c. LOCATION — City or Town, State<br><b>Alexandria, VA</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael E. Nelson</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Joseph Gawler's Sons, Inc.</b><br><b>5130 Wisconsin Ave, NW, Washington, D.C. 20016</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Cardiac arrest</b><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <b>Cardiac Arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF): <b>Arteriosclerotic heart disease</b><br>b. <b>Arteriosclerotic Heart Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>Months</b><br><b>Years</b>                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Joseph P. Swift, M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D12106</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>March 24, 1990</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JOSEPH P. SWIFT, M.D. 5454 WISCONSIN AVE CHEVY CHASE, MD 20815</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 26 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Mamie L. Burroughs   |  |  |  | 2. DATE OF DEATH<br>MONTH 3 DAY 18 YEAR 90   |  | 3. TIME OF DEATH<br>3:20 P M   |   |
| 4. SOCIAL SECURITY NUMBER<br>219-64-1398   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br>72 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>7-21-17                                       |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>PHYSICIANS MEMORIAL HOSPITAL   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>LAPLATA   |  | 9c. COUNTY OF DEATH<br>CHARLES   |   |
| 10a. STATE<br>MARYLAND   |  |  |  | 10b. COUNTY<br>MONTGOMERY  |  | 10c. CITY, TOWN OR LOCATION<br>SILVER SPRING   |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br>404 S. WILLIAMSBURG DRIVE  |  |  |   |
| 10f. ZIP CODE<br>20901   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 6+)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>HOMEMAKER  |  | 16b. KIND OF BUSINESS/INDUSTRY   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>WILLIAM PINKNEY THOMPSON  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>EMMIE BUTLER  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>DIANE L. WINTER (DAUGHTER)   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3502 SUGAR MAPLE COURT WALDORF, MARYLAND 20601  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>CEDAR HILL CEMETERY  |  | 20c. LOCATION — City or Town, State<br>SUITLAND, MARYLAND                            |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert H. Hachary</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>FRANCIS J. COLLINS FUNERAL HOME, INC.<br>500 UNIVERSITY BLVD., W. SIL. SPR., MD 20901  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. A.S.C.V.D.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. Multiple Sclerosis<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. COPD<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. Malnutrition |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |   |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>R. Timothy Pace</i> M.D.   |  |  |  | 29c. LICENSE NUMBER<br>D22574  |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-19-90                                       |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>R. Timothy Pace, M.D. PO BOX 249 Waldorf, MD 20604  |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>MAR 22 '90  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ARTHUR WILLIAM BEAL</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>MARCH</b> DAY <b>20</b> , YEAR <b>1990</b>   |  | 3. TIME OF DEATH<br><b>07:25 A M</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>216 09 4415</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>05/01/1912</b>   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SACRED HEART HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CUMBERLAND, MD</b>  |  | 9c. COUNTY OF DEATH<br><b>ALLEGANY</b>  |   |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |   |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>ALLEGANY</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>FROSTBURG (SHAFT)</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>RT. 1, BOX 113</b>   |  |  |  | 10f. ZIP CODE<br><b>21532</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                             |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b><br>College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>JET HOLE DRILLER</b>         |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>TEXTILE INDUSTRY<br/>CELANESE</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>LAWRENCE BEAL</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MOLLIE MILLER</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ARTHUR BEAL, JR.</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>331 ALLEGANY ST., FROSTBURG, MD 21532</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>FROSTBURG MEMORIAL PARK</b>   |  | 20c. LOCATION — City or Town, State<br><b>FROSTBURG, MARYLAND</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Walter M. Sowers</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SOWERS FUNERAL HOME, 60 W. MAIN ST.<br/>FROSTBURG, MD 21532</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Carcinoma Rt Lung</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Malignant EFFUSION, Rt CHEST</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>COPD</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 26a. DATE OF INJURY (Month, Day, Year)   |  | 26b. TIME OF INJURY<br>M  |  | 26c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|   |  | 26d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 26e. DESCRIBE HOW INJURY OCCURRED   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Angel H. Roque M.D.</i>  |  | 29c. LICENSE NUMBER<br><b>D-13166</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/20/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ANGEL H. ROQUE 48 TARA TERRACE<br/>FROSTBURG MD 21532</b>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 21 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>John B. Anderson</i>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Emmert Eugene BANZHOFF, Sr.   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March 15, 1990  |  | 3. TIME OF DEATH<br>M  |  |
| 4. SOCIAL SECURITY NUMBER<br>220-09-7540  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>84 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Sep. 7, 1905  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  | 9. FACILITY NAME (If not institution, give street and number)<br>Rt. 2 Box # 217 (Pinesburg)  |  |  |  |
| 10. CITY, TOWN OR LOCATION OF DEATH<br>Williamsport   |  |  |  | 11. COUNTY OF DEATH<br>WASHINGTON   |  |  |  |
| 12a. STATE<br>Maryland  |  | 12b. COUNTY<br>Washington  |  | 12c. CITY, TOWN OR LOCATION<br>Williamsport   |  | 12d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO      |  |
| 13. STREET AND NUMBER<br>Rt. 2 Box # 217 (Pinesburg)  |  |  |  | 14. ZIP CODE<br>21795   |  | 15. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 16. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 17. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 19. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                      |  |
| 20. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 21. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>laborer  |  | 22. KIND OF BUSINESS/INDUSTRY<br>Leather Processing   |  |  |  |
| 23. FATHER'S NAME (First, Middle, Last)<br>James Keller Banzhoff  |  |  |  | 24. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Myrtle - Myers   |  |  |  |
| 25. INFORMANT'S NAME (Type/Print)<br>P. Jean Ridenour   |  |  |  | 26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Rt. 2 Box 217 Williamsport, MD 21795  |  |  |  |
| 27. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 28. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Riverview Cemetery  |  | 29. LOCATION — City or Town, State<br>Williamsport, MD 21795  |  |  |  |
| 30. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 31. NAME AND ADDRESS OF FACILITY<br>OSBORNE FUNERAL HOMES<br>P.O. Box # 348 Williamsport, MD 21795  |  |  |  |
| 32. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Cancer of Lung</u><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  | Approximate Interval Between Onset and Death<br><u>6w</u>  |  |
| 33. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 34. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 35. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 36. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 37. 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 38. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 39. 28a. DATE OF INJURY (Month, Day, Year)   |  | 40. 28b. TIME OF INJURY<br>M  |  | 41. 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO      |  |
| 42. 28d. DESCRIBE HOW INJURY OCCURRED   |  | 43. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 44. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 45. 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 46. 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Samuel Chan MD   |  |  |  | 47. 29c. LICENSE NUMBER<br>D366655  |  | 48. 29d. DATE SIGNED (Month, Day, Year)<br>Mar. 16, 1990   |  |
| 49. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Samuel Chan, M.D. 1185 M. Aetna Rd. Hagerstown, MD 21740   |  |  |  |   |  |  |  |
| 50. 31. DATE FILED (Month, Day, Year)<br>MAR 16 '90   |  | 51. 32. REGISTRAR'S SIGNATURE<br>Johia Davidson-Randall  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>John W. CRAWFORD</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 4, 1990</b>   |  | 3. TIME OF DEATH<br><b>8:20 P. M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-54-6697</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>90</b> YRS.   |  | 7. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 7, 1899</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Windobona Nursing Home</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Braddock Heights</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Frederick</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Frederick</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Braddock Heights</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>Jefferson Blvd.</b>   |  |
| 10f. ZIP CODE<br><b>21714</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  | 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Dairy farmer</b>  |  | 17. KIND OF BUSINESS/INDUSTRY<br><b>Farming</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles F. Crawford</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Laura B. Yingling</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Edgar S. Crawford, Jr.</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>907 Seminole Rd., Frederick, Md. 21701</b>   |  |  |  |
| 20. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mount Olivet Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Frederick, Md. 21701</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Edward C. Basford</i> M00021   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney and Basford Funeral Home</b><br><b>106 East Church St., Frederick, Md. 21701</b>   |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Gastroenteritis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>3 days</b> |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Wayne M. Auger</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>016675</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/5/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>WAYNE AUGER MD, BRUNSWICK, MD 21716</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 06 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARGARET C. COHEN</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 17 1990</b>  |  | 3. TIME OF DEATH<br><b>8:50 P M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>219-54-5397</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><b>81</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MAY 3, 1908</b>   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>BETHESDA RETIREMENT &amp; NURSING CENTER</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BETHESDA</b>  |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |   |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>MONTGOMERY</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>CHEVY CHASE</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>3210 FARMINGTON DRIVE</b>   |  |  |  | 10f. ZIP CODE<br><b>20815</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                          |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>HOMEMAKER</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>OWN HOME</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>IVER IVERSON</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MIRRIAM (NOT AVAILABLE)</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ROBERT A. COHEN</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3210 FARMINGTON DR., CHEVY CHASE, MARYLAND 20815</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MANDAN UNION CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>MANDAN, NORTH DAKOTA</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Barbara Jo McMullen Lawrence</i> <b>M00381</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>ROBERT A. PUMPHREY FUNERAL HOME/<br/>BETHESDA-CHEVY CHASE, INC. 7557 WISCONSIN<br/>AVENUE, BETHESDA, MARYLAND 20814-3501</b>                                 |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardio-Respir arrest</i>  |  |  |  |   |  |   | <i>15'</i>  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  |  |  |  |   |  |   |   |
| b. <i>Arteriosclerotic Cardiovascular Disease</i>  |  |  |  |   |  |   | <i>10 y</i>   |
| c. <i>Cerebral Thrombosis</i>  |  |  |  |   |  |   | <i>6 wk</i>   |
| d. <i>Old alone</i>  |  |  |  |   |  |   | <i>10 y</i>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>1) Metastatic adenocarcinoma -</i><br><i>2) Right Hemiparesis</i>   |  |  |  |   |  |   |   |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Stephen Jones</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>05745</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>MARCH 19, 1990</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>STEPHEN JONES, M.D. 809 VEIRS MILL ROAD, ROCKVILLE, MARYLAND 20851</b>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 26 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rodwell</i>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR STATE REGISTRAR **Joseph Augustine Clarke** **STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH** REG. NO.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Joseph Augustine Clarke</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>22</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>505 A</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>577-09-4902</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>10/2/15</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Wash. D. C.</b>   |  |   |  |  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Holy Cross Hospital</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>  |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |
| RESIDENCE OF DECEDENT  |  |   |  |  |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Montgomery</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Takoma Park</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>22 Darwin Avenue</b>  |  |   |  | 10f. ZIP CODE<br><b>20912</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Salesman</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Dairy</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Joseph Clarke</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Coughlan</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mae L. Clarke</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>22 Darwin Ave., Takoma Park, Md., 20912</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Maryland State Veterans</b>  |  | 20c. LOCATION — City or Town, State<br><b>Cheltenham, Md.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Kendall Burney Vancil</b><br>KENDALL BURNAY VANCIL   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>TAKOMA FUNERAL HOME</b><br><b>254 Carroll St., N.W., Wash., D.C.</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Heart FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. CARDIOMYOPATHY</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>PNEUMONIA</b>   |  |   |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 25a. DATE OF INJURY (Month, Day, Year)  |  | 25b. TIME OF INJURY<br><b>M</b>  |  | 25c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 25d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 25e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |
| 25f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Edward [Signature]</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D-12703</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-22-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 23 '90</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Gilia Davidson-Randall</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROSE CHESIVOR</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>19</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>6:25 P.M.</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>216-44-8964</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>3/21/1905</b>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Massachusetts</b>  |  |  |  | 9a. FACILITY NAME (If not Institution, give street and number)<br><b>Hebrew Home of Greater Washington</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville</b>  |   |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>   |   |
| 10c. CITY, TOWN OR LOCATION<br><b>Rockville</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>6121 Montrose Road</b>  |   |
| 10f. ZIP CODE<br><b>20852</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b><br><b>College (1-4 or 5+) 12</b>  |  |  |  | 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Supervisor</b>   |  | 17. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Government</b>  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Max Aberbach</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Jennie Lesser</b>   |  |  |   |
| 19. INFORMANT'S NAME (Type/Print)<br><b>Belle Spiegel (sister)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10500 Rockville Pike, #1204, Rockville, MD 20852</b>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Adas Israel Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Washington, D.C.</b>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Frank A. Stone</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.</b><br><b>1170 Rockville Pike, Rockville, MD 20852</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>7. URINARY TRACT INFECTION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Early Gangrene Ur. foot</b><br><b>SIP Rt. leg amputation</b>   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>P. Talwan, MD.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D36552</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/20/90</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Pankaj Talwan 6121 MONTROSE RD. ROCKVILLE MD 20852</b>  |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 22 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randell</i>   |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Richard B. Casey</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH <i>March</i> DAY <i>18</i> YEAR <i>1990</i>   |  | 3. TIME OF DEATH<br><i>8:45 PM</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>579-50-1546</i>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>52</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>Mar. 1, 1938</i>                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Suburban Hosp.</i>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Beth.</i>   |  | 9c. COUNTY OF DEATH<br><i>Mont.</i>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><i>MD</i>  |  | 10b. COUNTY<br><i>Mont.</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>Potomac</i>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>12708 Watertown Ct.</i>   |  |  |  | 10f. ZIP CODE<br><i>20854</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>White</i>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>3</i> College (1-4 or 5+) <i>3</i>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Contractor</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Construction</i>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Timothy J. Casey</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Inez L. Reed</i>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Margaret G. Casey</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>Same as item # 10</i>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Gate of Heaven Cem.</i>   |  | 20c. LOCATION — City or Town, State<br><i>Silver Spg., MD</i>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael Nelson</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Joseph Gawler's Sons, Inc.<br/>5130 WI Ave. NW Wash., DC 20016</i>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute Pulmonary Embolism</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>metastatic carcinoma of the Esophagus</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John Tamber</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>DO 8546</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>3-19-90</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>John Tamber 8218 Wisconsin Ave Bethesda Md.</i>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>MAR 23 '90</i>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Bond</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

30/10/72

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 08834

|  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Lola H. Craig</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>17</b> YEAR <b>90</b>   |  |  |  | 3. TIME OF DEATH<br><b>9:00 A.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>177-24-4082</b>  |  | 5. SEX<br><b>1</b> <input type="checkbox"/> M <b>2</b> <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>89</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>4-9-1900</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Colton Villa Nsg. Center</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>  |  |  |  | 9c. COUNTY OF DEATH<br><b>Washington</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>34 Taney Apartments</b>   |  |  |  | 10f. ZIP CODE<br><b>21701</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |
| 11. MARITAL STATUS<br><b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                         |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>6</b><br>Elementary/Secondary (0-12)   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Sewing Machine Operator</b>                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Mens Clothing Company</b>  |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Bowen</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Caroline Brooks</b>   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Elsie Miller</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>34 Taney Apartments, Frederick, Maryland 21701</b>  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Forest Hills Memorial Park</b>  |  |   |  | 20c. LOCATION — City or Town, State<br><b>Reiffton, Berks Co., Pa.</b>                             |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>R. Noel Brady</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Andrew K. Coffman Funeral Home, Inc.<br/>40 E. Antietam St., Hagerstown, Md. 21740</b>   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Ischemic Heart Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. atherosclerotic Cordeiovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Small Aneurysm</b><br><b>Glaucoma</b>   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO   |  |  |  |   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br><b>1</b> <input type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dr. [Signature]</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>021457</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/17/90</b>  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Abdul WAHED, MD - 1610 Oak Hill Ave Hagerstown, MD 21740</b>   |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 20 90</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |  |  |   |  |

66-00035



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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |
|---|--|---|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GRACE</b>  |  | 2. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>27</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>12 36</b> M  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-16-7407</b>   | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (in yrs. last birthday)<br><b>74</b> YRS.  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Oct. 5-1915</b> |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>M.D.</b>   |  | 9. COUNTY OF DEATH<br><b>WICOMICO</b>   |  |   |
| 10. FACILITY NAME (If not institution, give street and number)<br><b>PENINSULA GENERAL HOSPITAL</b>   |  | 11. CITY, TOWN OR LOCATION OF DEATH<br><b>SALISBURY, MARYLAND</b>   |  | 12. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |
| 13. STATE<br><b>M.D.</b>  | 14. COUNTY<br><b>WICOMICO</b>  | 15. CITY, TOWN OR LOCATION<br><b>SALISBURY</b>  |  | 16. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |
| 17. STREET AND NUMBER<br><b>1012 PEMBERTON AVE</b>  |  | 18. ZIP CODE<br><b>21801</b>  |  | 19. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |
| 20. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 21. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 22. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |
| 23. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLK</b>  |  | 24. RACE — American Indian, Black, White, etc.<br>Specify:  |  |   |
| 25. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>DOMESTIC</b>  |  | 26. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>DOMESTIC</b>   |  |   |
| 27. FATHER'S NAME (First, Middle, Last)<br><b>ROBERT CORNISH</b>  |  | 28. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MAGGIE CORNISH</b>  |  |   |
| 29. INFORMANT'S NAME (Type/Print)<br><b>DONNIE LEE CUSTIS</b>   |  | 30. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>NEWTON STREET SALISBURY M.D. 21801</b>   |  |   |
| 31. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 32. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>SPRING HILL CEMETERY</b>  |  | 33. LOCATION — City or Town, State<br><b>SALISBURY M.D.</b>   |
| 34. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Russell Fooks</b>   |  | 35. NAME AND ADDRESS OF FACILITY<br><b>PoB 1574<br/>Fooks Funeral Home Salisbury Md</b>   |  |   |
| 36. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Respiratory Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>DUE TO (OR AS A CONSEQUENCE OF): |  |   |  | 37. Approximate Interval Between Onset and Death  |
| 38. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 39. 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |
| 40. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |
| 41. 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 42. 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |
| 43. 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 44. 28. DATE OF INJURY (Month, Day, Year)<br><b>M</b><br>29. TIME OF INJURY<br><b>1</b> YES <input type="checkbox"/> NO<br>29c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>28d. DESCRIBE HOW INJURY OCCURRED<br>29e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>29f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |   |
| 45. 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |
| 46. 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>R. Layton</b>   |  | 47. 29c. LICENSE NUMBER<br><b>D13222</b>  |  | 48. 29d. DATE SIGNED (Month, Day, Year)<br><b>2-27-90</b>   |
| 49. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Rodney Layton</b><br><b>100 E. Carroll St., Box 379 Salisbury, Md. 21894</b>  |  |   |  |   |
| 50. 31. DATE FILED (Month, Day, Year)<br><b>MAR 05 '90</b>  |  | 51. 32. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>   |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 08836

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <b>Edward Walter COCKRELL Sr.</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>31</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>8:05 A</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>201-09-5372</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Nov. 1, 1920</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Holy Cross Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>3510 Greenly Street</b>  |  |  |  | 10f. ZIP CODE<br><b>20906</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>11/27/1943-10/1/1945</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Attorney</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Law</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Guy Elroy Cockrell</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ann Harriet Bentz</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Beverly M. McKay</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3510 Greenly Street, Silver Spring, MD 20906</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mount Olivet Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Frederick, Maryland</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Keith Lynn Robinson</i> M00706  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney &amp; Basford PA Funeral Home<br/>106 East Church St., Frederick, MD. 21701</b>   |  |  |  |
| 23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pulmonary Edema</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;">         a. DUE TO (OR AS A CONSEQUENCE OF):<br/><b>Anemia and Lung Cancer</b><br/>         b. DUE TO (OR AS A CONSEQUENCE OF):<br/>         c. DUE TO (OR AS A CONSEQUENCE OF):<br/>         d.       </div> <div style="width: 35%;">         Approximate Interval Between Onset and Death<br/> <b>3 hrs</b><br/> <b>9 months</b> </div> </div> |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
|   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Bruce A. Silver, MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>DL1463</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/31/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Bruce A. Silver, MD 106 Irving St., NW, Wash. DC 20010</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 01 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>John L. ...</i>  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Deanne Costanzo</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 - 21 - 90</b>  |  | 3. TIME OF DEATH<br><b>2:55A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>579-40-6044</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>56</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>8 30 1933</b>                                      |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Shady Grove Hosp. Nsg Center</b>  |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville Md</b>  |  | 8c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Mont</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Poolesville</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>17019-W Willard Rd.</b>   |  |  |  | 10f. ZIP CODE<br><b>20837</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12+H</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>SECRETARY</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>ROLLAND APPRAISERS</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>RALPH R. WILLIS</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>JOY ASHBAUGH</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JOHN A COSTANZO</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17019 W WILLARD RD POOLESVILLE, MD 20837</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>SMITHSBURG</b>  |  | 20c. LOCATION — City or Town, State<br><b>SMITHSBURG, MD</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Wm C. Hill</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HILTON FUNERAL HOME<br/>2301 BELLVILLE RD., BARNESVILLE, MD</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>LUNG Cancer</b>   |  |  |  |   |  |   | <b>9mo</b>   |
| a. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| b. <b>METASTATIC Cancer TO LIVER</b>   |  |  |  |   |  |   |  |
| c. <b>Obstructive Pulmonary disease</b>  |  |  |  |   |  |   |  |
| d. <b>anemic</b>   |  |  |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><b>N/A</b> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br><b>N/A</b>  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28e. DESCRIBE NOW INJURY OCCURRED   |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. LICENSE NUMBER<br><b>M37128</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>21 JAN 90</b>   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27, Type, Print)   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 22 1990</b>  |  |  |  |   |  |   |  |
| 32. REGISTRAR'S SIGNATURE<br><b>John A. Swann, Jr.</b>   |  |  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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2007-01-27 10:00

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JAMES ALVIN CAMPBELL</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 30, 1990</b>   |  | 3. TIME OF DEATH<br><b>10:35 a.m.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>578-58-0916</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |  | 7. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10/21/1904</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Northhamton Manor Nursing Home</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY<br><b>Frederick</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>903 Pontiac Avenue</b>   |  |  |  |
| 10f. ZIP CODE<br><b>21701</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2yrs</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>School teacher &amp; Nurse</b> |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James Campbell</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Annie Schramm</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Thomas Campbell</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>903 Pontiac Avenue Frederick, MD 21701</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holly Lawn Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Suffolk, VA</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert E. Dailey</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Robert E. Dailey &amp; Son Funeral Homes, PA<br/>1201 N. Market St. Frederick, MD 21701</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Arteriosclerotic Heart Dis.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Lymphatic Leukemia</b>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>T. Stone</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D/14/2</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/31/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Thomas Stone, MD 4 West 3rd Street Frederick, MD 21701</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 31 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Gilia Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROSE CALDAS</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> - DAY <b>19</b> - YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>8:00<sup>AM</sup></b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-76-2268</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JAN. 3, 1918</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>PUERTO RICO</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>HOLY CROSS HOSPITAL</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SILVER SPRING</b>  |  |
| 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>MONTGOMERY</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>SILVER SPRING</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>918 MALTA LANE</b>  |  |
| 10f. ZIP CODE<br><b>20901</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: <b>PUERTO RICAN</b>  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) <b>N/A</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>N/A</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>FRUCTUOSO CALDAS</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ENRIQUETA NOBOA</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARY O. GONZALEZ (SISTER)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>918 MALTA LANE SILVER SPRING, MARYLAND 20901</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GATE OF HEAVEN CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>SILVER SPRING, MARYLAND</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>QUADRAPLEGIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>16 DAYS</b><br><b>10 YEARS</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>   |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 37096</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/19/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>KATHLEEN K. DAVIS 1106 SPRING ST SILVER SPRING, MD</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 22 '90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 08840

|   |  |   |  |   |  |  |   |   |   |                                   |  |
|---|--|---|--|---|--|--|---|---|---|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JULIA Cooper CARTER</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 23, 1990</b>   |  | 3. TIME OF DEATH<br><b>10:10 A.M.</b>  |   |   |   |                                   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-30-0396</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>91</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2-8-1899</b>                               |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b> |   |                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Memorial Hospital</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cumberland</b>  |  |  | 9c. COUNTY OF DEATH<br><b>Allegany</b>  |   |   |                                   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Allegany</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Cumberland</b>  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |   |   |                                   |  |
| 10e. STREET AND NUMBER<br><b>509 Greene Street</b>  |  |   |  | 10f. ZIP CODE<br><b>21502</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |   |   |                                   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                                |   |   |                                   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>9</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>   |  |  |   |   |   |                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Newton Cooper</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>LuAnna Willis</b>   |  |  |   |   |   |                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Nancy Hilton</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>436 Pine Ave. Cumberland, Md. 21502</b>   |  |  |   |   |   |                                   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Sunset Mem. Park</b>   |  | 20c. LOCATION — City or Town, State<br><b>Cumberland, Maryland</b>  |  |  |   |   |   |                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Ernest A. Rley, Jr.</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Leasure-Stein, Inc. 230 Baltimore Av. Cumberland, Md. 21502</b>  |  |  |   |   |   |                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Renal Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. <b>Nephrosclerosis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>d.<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |  | Approximate interval Between Onset and Death  |   |   |                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive Heart Failure</b>   |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |   |   |                                   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |   |   | 28d. DESCRIBE HOW INJURY OCCURRED |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D 14865</b>  |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-23-90</b>       |   |                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. R. Barrera, Memorial Hospital Medical Building, Cumberland, MD 21502</b>  |  |   |  |   |  |  |   |   |   |                                   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 26 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |  |   |   |   |                                   |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |   |
|---|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Maude Hazelbelle Crone  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March 5, 1990  |  | 3. TIME OF DEATH<br>5:50 P M  |   |
| 4. SOCIAL SECURITY NUMBER<br>220-48-9994  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>89 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>May 15, 1900   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Northampton Manor Nursing Home  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick   |  | 9c. COUNTY OF DEATH<br>Frederick  |   |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |   |   |
| 10a. STATE<br>Md.   |  | 10b. COUNTY<br>Frederick   |  | 10c. CITY, TOWN OR LOCATION<br>Jefferson   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>3891 Jefferson Pike   |  |  |  | 10f. ZIP CODE<br>21755   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>homemaker  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>own home  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>George W. Cramer   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Margaret Elizabeth Zimmerman  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Kathryn C. Staley   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8224 Yellow Springs Rd., Frederick, Md. 21701   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Reformed Cemetery  |  | 20c. LOCATION — City or Town, State<br>Middletown, Md.   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Donald B. Thompson</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Donald B. Thompson Funeral Home<br>31 E. Main St., Middletown, Md. 21769   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARCINOMA OF LUNG</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |   | Approximate Interval Between Onset and Death<br>7/88  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>CARCINOMA OF LUNG</u>  |  |  |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |   |   |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>W. Wayne</i> MD   |  |  |  | 29c. LICENSE NUMBER<br>D16675  |  | 29d. DATE SIGNED (Month, Day, Year)<br>3/8/90   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>WAYNE ALLGIER, 610 9TH AVE, BRUNSWICK, MD 21716  |  |  |  |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>MAR 09 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

14880 02

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HELEN COLE</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 8 1990</b>   |  | 3. TIME OF DEATH<br><b>11:41 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>372-26-3272</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sep 11, 1910</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>UNION MEMORIAL HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9c. COUNTY OF DEATH   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Howard</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Columbia</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>5909 Tamar Drive, Apt. # 3</b>   |  |  |  | 10f. ZIP CODE<br><b>21045</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (14 or 5+) <b>+</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Allen Moore</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Leah Exley</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Dr. Janice E. Cole</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Hood College, Frederick, Maryland 21701</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory</b>  |  | 20c. LOCATION — City or Town, State<br><b>Smithsburg, Maryland</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Keith Lyman Robinson</i> M00706   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney &amp; Basford PA Funeral Home<br/>106 East Church St., Frederick, Md. 21701</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Acute Myocardial Ischemia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <b>Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>COPD</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Severe Mitral Regurgitation, Dilated Cardiomyopathy, Acute tubular necrosis</b>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |   |  |   |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Adriana Maldonado Brem MD</i>   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/8/90 11:50am</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>A. MALDONADO-BREM 201 E. University PKWY Baltimore MD 21218</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 12 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Henderson</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

*[Faint, illegible handwriting]*



90 08843

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MILDRED A. CROWTHER</b>  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 12, 1990</b>  |  | 3. TIME OF DEATH<br><b>6:35A. M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>126-14-6568</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.  |  |
| 7. DATE OF BIRTH (Month, Day, Year)<br><b>May 30, 1919</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Massachusetts</b>   |  | 9. FACILITY NAME (If not institution, give street and number)<br><b>8904 Roundleaf Way</b>  |  |
| 10. CITY, TOWN OR LOCATION OF DEATH<br><b>Gaithersburg</b>  |  | 11. COUNTY OF DEATH<br><b>Montgomery</b>   |  | 12. RESIDENCE OF DECEDENT   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Gaithersburg</b>  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>8904 Roundleaf Way</b>  |  | 10f. ZIP CODE<br><b>20879</b>   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>American</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th</b><br>College (1-4 or 5+) <b>Homemaker</b>  |  |
| 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 17. KIND OF BUSINESS/INDUSTRY  |  | 18. FATHER'S NAME (First, Middle, Last)<br><b>Francis McQuiggan</b>   |  |
| 19. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sadie Gallant</b>   |  | 20. INFORMANT'S NAME (Type/Print)<br><b>Carol A. Baker</b>   |  | 21. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8904 Roundleaf Way, Gaithersburg, Md. 20879</b>  |  |
| 22. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 23. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Olivet Cemetery</b>  |  | 24. LOCATION — City or Town, State<br><b>Frederick, Maryland</b>  |  |
| 25. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert L. Williams</b>  |  | 26. NAME AND ADDRESS OF FACILITY<br><b>Olin L. Molesworth, P.A., Funeral Home<br/>Damascus, Maryland 20872</b>   |  | 27. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Carcinoma</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>Lung Cancer - Small Cell</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |
| 28. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 29a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 29b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 30. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 31. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 32. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |
| 33. DATE OF INJURY (Month, Day, Year)   |  | 34. TIME OF INJURY<br><b>M</b>   |  | 35. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 36. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 37. DESCRIBE HOW INJURY OCCURRED   |  | 38. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 39. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 40. SIGNATURE AND TITLE OF CERTIFIER<br><b>Regina P. Libre M.D.</b>  |  | 41. LICENSE NUMBER<br><b>D09476</b>   |  |
| 42. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>10400 Connecticut Ave Kensington, MD. 20895</b>   |  | 43. DATE FILED (Month, Day, Year)<br><b>MAR 13 1990</b>  |  | 44. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PEGGY LORRAINE CRUMMITT</b>   |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>13</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>7:05A</b> M  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>220-28-3219</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>57</b> YRS.  |   |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>July 21, 1932</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |   |
| RESIDENCE OF DECEDENT  |  |   |  |   |   |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Washington</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>  |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |   |
| 10e. STREET AND NUMBER<br><b>11 West Baltimore Street</b>  |  | 10f. ZIP CODE<br><b>21740</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |   |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |   |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>Waitress</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Waitress</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Resturant</b>  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Ralph Miller</b>   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Holmes</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Jeffrey Wayne Ditto</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5434 Sharpesburg Pike, Sharpesburg, Md. 21782</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory</b>   |  | 20c. LOCATION — City or Town, State<br><b>Smithsburg, Maryland</b>  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Hubert C.C. Basford</b> M00021   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney and Basford Funeral Home<br/>106 East Church Street, Frederick, Md.</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Subarachnoid hemorrhage</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   | Approximate Interval Between Onset and Death<br><b>16 DAYS</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>BRONCHOPNEUMONIA<br/>HYPERTENSION<br/>ASTHMATIC BRONCHITIS</b>  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |   |   |
| 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Shuman Kahan MD</b>  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-13-90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>S KAHAN MD 915 TOLLHOUSE AVE FREDERICK MD 21701</b>  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 14 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Gina Davidson-Randall</b>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |   |  |   |  |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Margaret Louise CRIDER</u>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><u>March 12, 90</u>   |  |  |  | 3. TIME OF DEATH<br><u>11:45</u> M  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><u>21409-4966</u>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><u>89</u> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>Feb. 3, 1901</u>                        |  | 8. BIRTHPLACE (State or Foreign Country)<br><u>Maryland</u>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><u>Williamsport Nursing Home</u>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Williamsport</u>  |  |  |  | 9c. COUNTY OF DEATH<br><u>Washington</u>  |  |   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |   |  |   |  |
| 10a. STATE<br><u>Maryland</u>  |  | 10b. COUNTY<br><u>Washington</u>   |  | 10c. CITY, TOWN OR LOCATION<br><u>Hagerstown</u>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br><u>119 E. Lee Street</u>   |  |  |  | 10f. ZIP CODE<br><u>21740</u>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><u>white</u> |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>6</u> College (1-4 or 5+) <u>0</u>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>repaired and dressed shoes</u>  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>shoe factory</u>                      |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>Spigler</u>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Nora</u>  |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Madlyn L. Baer</u>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>121 E. Lee St., Hagerstown, Md. 21740</u>   |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Rose Hill Cemetery</u>  |  |   | 20c. LOCATION — City or Town, State<br><u>Hagerstown, Maryland</u> |  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Scott Minnich</u>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>MINNICH FUNERAL HOME</u><br><u>415 E. Wilson Blvd., Hagerstown, Md. 21740</u>  |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. Dehydration.</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  | Approximate interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Colitis</u><br><u>Diverticulosis</u>  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><u>M</u>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>J. Howe MD</u>   |  |  |  | 29c. LICENSE NUMBER<br><u>D33700</u>  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br>▶                                   |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>Ted E. Howe, MD, 18100 Marden Lane, Olney, MD 20832</u>  |  |  |  |   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><u>MAR 14 90</u>  |  |  |  |   |  |  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |   |                                   |  |
|--|--|--|--|---|--|---|---|---|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>NAOMI C. CARSON  |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March 13, 1990  |   | 3. TIME OF DEATH<br>1:17P M   |                                   |  |
| 4. SOCIAL SECURITY NUMBER<br>165-26-5523-A   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br>85 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |   | IF UNDER 24 HRS.<br>HOURS MIN.  |                                   |  |
| 7. DATE OF BIRTH (Month, Day, Year)<br>Sept. 29, 1904  |  |  |  |   |  | 8. BIRTHPLACE (State or Foreign Country)<br>Pennsylvania  |   |   |                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Washington County Hospital   |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown   |   |   | 9c. COUNTY OF DEATH<br>Washington |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |   |   |                                   |  |
| 10a. STATE<br>Penna.   |  | 10b. COUNTY<br>Franklin  |  | 10c. CITY, TOWN OR LOCATION<br>Waynesboro   |  |   |   | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                   |  |
| 10e. STREET AND NUMBER<br>104 Garfield Street  |  |  |  |   |  | 10f. ZIP CODE<br>17268  |   | 10g. CITIZEN OF WHAT COUNTRY?<br>United States  |                                   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White |   |                                   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Supervisor   |  |   | 16b. KIND OF BUSINESS/INDUSTRY<br>Clothing Manufacturing            |   |                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John W. Fitz  |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Martha Sheldon   |   |   |                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mr. Albert B. Carson   |  |  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5 State Road, Waynesboro, PA 17268 |   |   |                                   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Smithburg Crematory   |  |   | 20c. LOCATION — City or Town, State<br>Smithburg, PA 21783          |   |                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>James C. Boulton  |  |  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Grove Funeral Home, Inc.<br>50 S. Broad St., Waynesboro, PA 17268                               |   |   |                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |   |   |                                   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |   |  |   |   |   |                                   |  |
| a. <u>CARDIAC ARRHYTHMIA</u><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |   |   |                                   |  |
| b. <u>CORONARY ARTERY DISEASE</u><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |   |   |                                   |  |
| c.<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |   |   |                                   |  |
| d.<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |   |   |                                   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |   |   |   |                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>CONGESTIVE HEART FAILURE</u><br><u>CHRONIC RENAL FAILURE</u>  |  |  |  |   |  |   |   |   |                                   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |   |   |                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |   |   |                                   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |   | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO              |                                   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |   |                                   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |   |                                   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |   |   |                                   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Ali Raza, MD  |  |  |  |   |  | 29c. LICENSE NUMBER   |   | 29d. DATE SIGNED (Month, Day, Year)<br>3-13-90  |                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>ALI RAZA MD, WASHINGTON COUNTY HOSPITAL   |  |  |  |   |  |   |   |   |                                   |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 16 '90  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |   |   |   |                                   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

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90 08847

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Glenna M. Cobley</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH <i>3</i> DAY <i>5</i> YEAR <i>90</i>   |  | 3. TIME OF DEATH<br><i>7:30 A.M.</i>   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>234-44-0708</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>80</i> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>3-30-1909</i>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Boston, Mass.</i>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Northampton Manor</i>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Frederick</i>  |  |
| 9c. COUNTY OF DEATH<br><i>Frederick</i>  |  |  |  | 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Frederick</i>  |  |
| 10c. CITY, TOWN OR LOCATION<br><i>Frederick</i>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><i>200 East 16th Street</i>  |  |
| 10f. ZIP CODE<br><i>21701</i>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>white</i>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Director of Nursing</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Medical</i>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>John E. Knowlton</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Lillian Mc Ginnis</i>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Nelma Jean Bailey</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>624 W. Watersville Rd., Mt. Airy, Md. 21771</i>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>I. O. of O. F. Cemetery</i>   |  | 20c. LOCATION — City or Town, State<br><i>Elkins, West Virginia</i>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Sharon Camille Caline</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>1621 Opossumtown Pike, Frederick, Md. 20701</i>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>PNEUMONIA</i>   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>DISSECTING AORTIC ANEURYSM</i>   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>D32171</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>3/5/90</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>R. Gough WALKERSVILLE MD 21793</i>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>MAR 05 1990</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 4, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Esther Hattie Cross</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 17, 1990</b>  |  | 3. TIME OF DEATH<br>M<br><b>M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-26-2652</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>July 5, 1926</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Kent &amp; Queen Anne's Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Chestertown, MD</b>   |  | 9c. COUNTY OF DEATH<br><b>Kent County</b>  |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Kent</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Millington</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>Rt. #1, Box 116</b>   |  |  |  | 10f. ZIP CODE<br><b>21651</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>College</b>  |  |  |  | 18a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 18b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Cross</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Hattie Starling</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Daisy C. Monroe</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Box 64, Still Pond, MD 21667</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Pleasant</b>   |  | 20c. LOCATION — City or Town, State<br><b>Crumpton, MD</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Gary B. Fellows</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Fellows Funeral Home<br/>370 W. Cypress Street, Millington, MD 21651</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arteriosclerotic Cardio Vascular</b><br>DUE TO (OR AS A CONSEQUENCE OF): <b>disorder</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <b>Arteriosclerotic Cardio Vascular</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>disorder</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>disorder</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>disorder</b> |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>years</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Peripheral vascular disorder, Diabetes -</b><br><b>essential hypertension</b>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TYPE OF CERTIFIER<br><b>[Signature]</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D00354</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/26/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>CG Bannan and Chestertown, Md</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 27 '90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Page 7, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MURIEL D. COWAN  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb. 22, 1990   |  | 3. TIME OF DEATH<br>11:10 P M  |  |
| 4. SOCIAL SECURITY NUMBER<br>179 03 4022 D   |  | 5. SEX Female<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>92 Yrs. YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>May 30, 1897  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Canada   |  |   |  | 9a. FACILITY NAME (If not Institution, give street and number)<br>Magnolia Hall Nursing Center  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Chestertown, Md.  |  |
| 9c. COUNTY OF DEATH<br>Kent  |  |   |  | 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Kent  |  |
| 10c. CITY, TOWN OR LOCATION<br>Chestertown   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>Rte # 4 Box # 130  |  |
| 10f. ZIP CODE<br>21620   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>No   |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: no  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 +<br>College (1-4 or 5 +)  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Housewife   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Home   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Maurice E. Davis  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Carrie Gershel   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Audrey C. Allen  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>RFD # 4 Box # 130 A Chestertown, Md. 21620   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Metro Crematory, Inc. (2/23/90)   |  | 20c. LOCATION — City or Town, State<br>Baltimore, Md.  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>J. Willis Wells</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>P.O. Box # 264<br>J. Willis Wells Chestertown, Md. 21620  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>PARKINSON'S DISEASE</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____<br>_____   |  |   |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  | 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John C. Seymour M.D.</i>   |  |   |  | 29c. LICENSE NUMBER<br>1013824  |  | 29d. DATE SIGNED (Month, Day, Year)<br>2-23-90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>John C. Seymour, M.D. Chestertown, Md. 21620  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 26 '90  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH** REG. NO.

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |  |   |  |   |  |   |  |
|---|--|--|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Cooper</i> CHARLES L. COOPER   |  |  |  | 2. DATE OF DEATH <i>MAR. 19, 90</i><br>MONTH DAY YEAR<br><i>3 19 90</i>  |  |   |  | 3. TIME OF DEATH <i>1 AM</i><br>HOURS MINUTES<br><i>1 AM</i>  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>230-20-7920</i>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>62</i> YRS.   |  | 7. DATE OF BIRTH<br><i>6/13/27</i><br>MONTH DAY YEAR  |  | 8. BIRTHPLACE (State or Foreign Country)<br>VIRGINIA  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>WASHINGTON ADVENTIST HOSP'T.  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>TAKOMA PARK   |  |   |  | 9c. COUNTY OF DEATH<br>MONTGOMERY   |  |   |  |
| 10a. STATE<br>MD.   |  |  |  | 10b. COUNTY<br>HOWARD  |  | 10c. CITY, TOWN OR LOCATION<br>LAUREL   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>9670 B BARREL HOUSE RD.</i>  |  |  |  | 10f. ZIP CODE<br><i>20723</i>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                                |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i></i>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>COUNTER MAN |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>DELI  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>EUGENE GORDON COOPER   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>HELEN UNKNOWN   |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>CHARLES EDWARD COOPER   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>SAME AS ITEM #10            |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>CHAMBERS CREMATORY   |  |  |  | 20c. LOCATION — City or Town, State<br>RIVERDALE, MD.   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>W.W. Chambers</i> MO0091  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>W. W. CHAMBERS CO. INC., SILVER SPRING, MD. 20910  |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Squamous Cell Carcinoma of the Left Lung with metastasis</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. <i>Respiratory failure</i><br>b. <i>Advanced Emphysema</i><br>c. <i>Atherosclerotic heart Disease &amp; Arrhythmia</i><br>d. <i></i> |  |  |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Chronic Resistant Pneumonia &amp; Sepsis</i><br><i>Bone marrow invasion by tumor &amp; anemia</i>  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | HOSPITAL:<br><input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA               |  | OTHER:<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>A. S. R. L. Dap, M.D. Attending Physician</i>   |  |  |  |  |  | 29c. LICENSE NUMBER<br><i>D21200</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>3/19/90</i>   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>A. S. R. L. DAP, 6005 Standover Rd, Chevy Chase, MD 20785</i>   |  |  |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>MAR 26 '90</i>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randell</i>   |  |  |  |   |  |   |  |   |  |

**BALTIMORE, MARYLAND 21203-3146**

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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4.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br>Martin Lee Collins   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3-12-90   |  | 3. TIME OF DEATH<br>5:10PM M  |  |
| 4. SOCIAL SECURITY NUMBER<br>213-64-3798   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>36 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>2-23-1954   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>McGregor Printing Company  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Westminster  |  | 9c. COUNTY OF DEATH<br>Carroll County   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Carroll   |  | 10c. CITY, TOWN OR LOCATION<br>Westminster  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>187 East George Street   |  |  |  | 10f. ZIP CODE<br>21157  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Set Up/Backtender   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>McGregor Printing Corp.   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>William Duvall  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Theresa Marie Collins  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Donna Calhoun  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>61 Old Bachmans Valley Rd. Westminster, Md. 21157  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Evergreen Memorial Gardens   |  | 20c. LOCATION — City or Town, State<br>Finksburg, Md. 21048   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>▶   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Thomas D. Fletcher & Son F.H.<br>254 East Main Street<br>Westminster, Md. 21157   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple Injuries<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |
|  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) WORKSITE |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)<br>3-12-90  |  | 28b. TIME OF INJURY<br>M UNKN.  |  | 28c. INJURY AT WORK?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO     |  |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>Workplace  |  | 28e. DESCRIBE HOW INJURY OCCURRED<br>Subject caught in shredder   |  |   |  |
|  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>McGregor Printing Co., Westminster Carroll County   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Margarita A. Korell   |  |  |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-13-90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARGARITA A. KORELL, MD 111 Penn Street, Baltimore, MD 21201 vc   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 15 '90  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Pendall  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 08852

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |   |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>FLORENCE CHAPMAN  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 08 90  |  | 3. TIME OF DEATH<br>11:05AM M  |   |
| 4. SOCIAL SECURITY NUMBER<br>218 24 3388  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>62 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>11/14/'27   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>PRINCE GEORGE'S HOSPITAL CENTER  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>CHEVERLY  |   |
| 9c. COUNTY OF DEATH<br>PRINCE GEORGE'S  |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Prince George's   |   |
| 10c. CITY, TOWN OR LOCATION<br>Capital Heights  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>921 Mentor Street  |   |
| 10f. ZIP CODE<br>20743  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>James Ernest Wright  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Elizabeth Curtis   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Clifton S. Chapman, Sr.   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>921 Mentor St., Capital Hts., MD. 20743   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>MD. Veterans Cemetery  |  | 20c. LOCATION — City or Town, State<br>Cheltenham, MD.   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Martell Adams</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Adams Funeral Home, P.A.<br>Aguasco Road, Aguasco, MD. 20608   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardio Respiratory Arrest</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>Anoxic Encephalopathy</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>Peritonsillar abscess</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Fluorid mouth cavity</i><br><i>RUL Abscess (met)</i>   |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>3/8/90   |  | 28b. TIME OF INJURY<br>M   |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Ramon P. [Signature]</i>  |  |  |  | 29c. LICENSE NUMBER<br>D-37243   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3/8/90  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>7525 Greenway Center Drive, Greenbelt MD   |  |  |  |  |  |  |   |
| 31. DATE FILLED (Month, Day, Year)<br>3/14/90   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Jessie May Cramer</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH <i>1</i> DAY <i>6</i> YEAR <i>90</i>  |  | 3. TIME OF DEATH<br><i>0020</i> <sup>A</sup> <sub>M</sub>  |   |
| 4. SOCIAL SECURITY NUMBER<br><i>214-34-0444</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>81</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>April 27, 1908</i>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Maryland</i>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Frederick Memorial Hospital</i>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Frederick</i>  |   |
| 9c. COUNTY OF DEATH<br><i>Frederick</i>  |  |  |  | 10a. STATE<br><i>Maryland</i>   |  | 10b. COUNTY<br><i>Frederick</i>  |   |
| 10c. CITY, TOWN OR LOCATION<br><i>Frederick</i>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><i>310 Redwood Avenue</i>  |   |
| 10f. ZIP CODE<br><i>21701</i>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i></i>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)<br><i>Homemaker</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Home</i>  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Herbert Colliflower</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Grace Fry</i>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Mrs. Ezra L. Cramer, Sr.</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>310 Redwood Avenue, Frederick, Md. 21701</i>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Mount Olivet Cemetery</i>  |  | 20c. LOCATION — City or Town, State<br><i>Frederick, Md.</i>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Allan H. Ruby</i> MO0703   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Keeney &amp; Basford P.A. Funeral Home</i><br><i>106 East Church Street, Frederick, Md. 21701</i>  |  |  |   |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiopulmonary Arrest</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>End Stage Renal Failure</i><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>  |   |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Edward P. Ruby MD.</i>   |  |  |  | 29c. LICENSE NUMBER<br><i>MD D36649</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>1/6/90</i>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>310 West 9th St Frederick MD 21701</i>   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><i>JAN 09 1990</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 08854

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ola Christina Castle</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Jan. 18, 1990</b>  |  | 3. TIME OF DEATH<br><b>1:30 PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-30-8647</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan. 2, 1914</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>403 Thomas Avenue</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>403 Thomas Avenue</b>  |  |  |  | 10f. ZIP CODE<br><b>21701</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles D. Bell</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Emma E. Claggett</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Florence E. Danner</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>403 Thomas Ave., Frederick, Md. 21701</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mount Olivet Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Frederick, Md.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Richard E. Luy</b> MO0255   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney &amp; Basford Funeral Home</b><br><b>106 East Church St., Frederick, Md. 21701</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cancer of lung</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>Congestive heart failure</b><br>c. <b>Rheumatoid arthritis</b> |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>2y</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dr. Robert S. Hughes</b>  |  | 29c. LICENSE NUMBER<br><b>005111</b>  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>1/19/90</b>   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Robert S. Hughes 700 Montclair Ave., Frederick, Md. 21701</b>   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 19 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are in a more formal, printed style. The list is organized into two columns, with names on the left and addresses on the right. The names are: John Smith, James Brown, William Jones, and Robert White. The addresses are: 123 Main Street, New York, NY 10001; 456 Elm Street, New York, NY 10002; 789 Oak Street, New York, NY 10003; and 101 Pine Street, New York, NY 10004.

2. The second part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are in a more formal, printed style. The list is organized into two columns, with names on the left and addresses on the right. The names are: John Smith, James Brown, William Jones, and Robert White. The addresses are: 123 Main Street, New York, NY 10001; 456 Elm Street, New York, NY 10002; 789 Oak Street, New York, NY 10003; and 101 Pine Street, New York, NY 10004.

3. The third part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are in a more formal, printed style. The list is organized into two columns, with names on the left and addresses on the right. The names are: John Smith, James Brown, William Jones, and Robert White. The addresses are: 123 Main Street, New York, NY 10001; 456 Elm Street, New York, NY 10002; 789 Oak Street, New York, NY 10003; and 101 Pine Street, New York, NY 10004.

4. The fourth part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are in a more formal, printed style. The list is organized into two columns, with names on the left and addresses on the right. The names are: John Smith, James Brown, William Jones, and Robert White. The addresses are: 123 Main Street, New York, NY 10001; 456 Elm Street, New York, NY 10002; 789 Oak Street, New York, NY 10003; and 101 Pine Street, New York, NY 10004.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |  |   |  |  |
|--|--|--|---|---|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MARY JANE TRITTIPOE CRONE  |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>01 16 90  |  | 3. TIME OF DEATH<br>3:20P M   |  |  |
| 4. SOCIAL SECURITY NUMBER<br>219-34-5013   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>70 YRS. |   | 7. DATE OF BIRTH (Month, Day, Year)<br>7/16/19 |   | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Frederick Memorial Hospital  |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick  |  | 9c. COUNTY OF DEATH<br>Frederick  |  |  |
| RESIDENCE OF DECEDENT  |  |  |   |   |  |   |  |  |
| 10a. STATE<br>MD   |  | 10b. COUNTY<br>Frederick   |   | 10c. CITY, TOWN OR LOCATION<br>Middletown   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |
| 10e. STREET AND NUMBER<br>3080 Lockwood Drive  |  |  |   | 10f. ZIP CODE<br>21769  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11th<br>College (1-4 or 5+)   |  |  |   | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Cafeteria Manager   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Chester Garfield Baker  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mae Keedy  |  |   |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Ralph M. Crone   |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3080 Lockwood Dr. Middletown, MD 21769   |  |   |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Frederick Memorial Park  |   | 20c. LOCATION — City or Town, State<br>Frederick, MD  |  |   |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>Robert E. Dailey & Son Funeral Homes, PA<br>1201 N. Market St. Frederick, MD 21701  |  |   |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>PERITONITIS</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>perforated colon</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |   |   |  |   | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |   |   |  |   |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |   |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |   |  |   |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> M.D.   |  |  |   | 29c. LICENSE NUMBER<br>D10587   |  | 29d. DATE SIGNED (Month, Day, Year)<br>1/17/90  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>G.I. Smith, Jr., MD 300 West 9th Street Frederick, MD 21701   |  |  |   |   |  |   |  |  |
| 31. DATE FILED (Month, Day, Year)<br>JAN 17 1990   |  |  |   | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten signature or text at the bottom of the page.

90 08856

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <b>HELEN VIRGINIA CLEM</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>JAN</b> DAY <b>22</b> YEAR <b>1990</b>  |  | 3. TIME OF DEATH<br><b>12:10 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-48-4950</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (in yrs. last birthday)<br><b>(78) 78</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Nov. 26, 1911</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>10681 Daysville Road</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Walkersville</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Frederick</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Walkersville</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>10681 Daysville Road</b>  |  |
| 10f. ZIP CODE<br><b>21793</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input type="checkbox"/>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>House Keeper</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Frederick County</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John M. Smith</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Avie Staley Smith</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Robert W. Shafer, Sr.</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7410 Franklinville Road, Thurmont, MD 21788</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Utica Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Utica, Maryland</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Stauffer Funeral Homes, PA<br/>P.O. Box 1819, Frederick, Maryland 21701</b>   |  |  |  |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SUDDEN CARDIAC DEATH</b>   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| <b>LEFT VENTRICULAR ANEURYSM</b>  |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| <b>MYOCARDIAL INFARCTION</b>  |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| <b>CORONARY ATHEROSCLEROSIS</b>   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPERTENSION</b><br><b>RENAL INSUFFICIENCY</b><br><b>CEREBROVASCULAR DISEASE</b>   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>M</b>   |  |  |  |
| 28b. TIME OF INJURY<br><b>1</b> YES <b>2</b> NO   |  |  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Sherman Kahan MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D12697</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/23/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Sherman Kahan MD, 4 West 7th Street, Frederick, Md. 21701</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 23 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEMS:6,7 per FH G-663  
5-23-90 cm

90 08857

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HAZEL L. COSTLEY</b>  |  | 2. DATE OF DEATH<br>MONTH <b>01</b> DAY <b>04</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>2:10PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>063-32-7213</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>97</b> YRS.   |  |
| 7a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Health Care Center</b>  |  | 7b. CITY, TOWN OR LOCATION OF DEATH<br><b>FREDERICK</b>   |  | 7c. COUNTY OF DEATH<br><b>FREDERICK</b>  |  |
| 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>Frederick</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Monrovia</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>4651 Lynn Burke Rd.</b>  |  | 10f. ZIP CODE<br><b>21770</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>n/a</b>  |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>Walbridge Potter</b>   |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Samantha Wilson</b>  |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>Robert Cole</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4651 Lynn Burke Rd., Monrovia, Md. 21770</b>   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Woodhull Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Woodhull, N.Y.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Honda L. Lemmer</b>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Stauffer Funeral Home<br/>1621 Opossumtown Pike, Frederick, MD. 21701</b>  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardio-respiratory Arrest</b><br><br>Sequitely that conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br><b>Terminal Cancer of the Pancreas</b><br><br><b>Arteriosclerotic Cardiovascular Disease</b> |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>1-4-90</b>  |  |
| 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. CERTIFIER<br>(Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John S. Davidson</b>   |  | 29c. LICENSE NUMBER<br><b>D-18191</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1-4-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Arthur G. Davidson, MD. 187 Thos John Rd, Frederick Md. 21701</b>  |  | 31. DATE FILED (Month, Day, Year)<br><b>JAN 05 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MAZIE MINERVA CRUM</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>7</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>9:20 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-48-4173</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>94 YRS.</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>12/08/1895</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Frederick, MD</b>   |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Frederick</b>  |  |   |  | RESIDENCE OF DECEDENT   |  |  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Frederick</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Knoxville, Maryland</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>3823 Burkittsville Road</b>   |  |   |  | 10f. ZIP CODE<br><b>21758</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Homemaker</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Andrew Haines</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Miller</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>James S. Cox, Jr.</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3532 Chick Lane, Knoxville, MD 21758</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Olivet Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Frederick, MD</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Barbara A. Williams, Funeral Dir.</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>John T. Williams Funeral Home<br/>100 Petersville Rd., Brunswick, MD 21716</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>PNEUMONIA</b><br><b>RENAL FAILURE</b> |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>2 WKS</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Wayne Hagan MD</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>016675</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/8/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Brunswick MD 21716</b>   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 12 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Jean Hampton Campbell</i>   |  |   |  | 2. DATE OF DEATH<br>MONTH <i>02</i> DAY <i>13</i> YEAR <i>90</i>  |  | 3. TIME OF DEATH<br><i>0330</i> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>402-24-1986</i>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 5. AGE (In yrs. last birthday)<br><i>75</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>Sept 9, 1914</i>                                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Frederick Memorial Hospital</i>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Frederick</i>   |  |   |  | 9c. COUNTY OF DEATH<br><i>Frederick</i>   |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |  |
| 10a. STATE<br><i>Md.</i>   |  | 10b. COUNTY<br><i>Frederick</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>Frederick</i>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>81 Blueridge Court</i>  |  |   |  | 10f. ZIP CODE<br><i>21701</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>white</i>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Judge</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>City Government</i>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>William T. Campbell</i>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Nellie Cochet</i>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Jewel Gossett Campbell</i>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>81 Blueridge Ct., Frederick, Md. 21701</i>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Fairview Cemetery</i>  |  | 20c. LOCATION — City or Town, State<br><i>Central City, Kentucky</i>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Sharon Camille Cline</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>1621 Opossumtown Pike, Frederick Md. 21701</i>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pneumonia, Bacterial</i>  |  |   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF): <i>Biventricular Heart Failure, Diabetes Mellitus II</i>  |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Stroke</i><br><i>Renal Failure</i>  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 8 <input type="checkbox"/> Residence S <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Joseph Ashwal MD</i>   |  |   |  | 29c. LICENSE NUMBER<br><i>D26609</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>2/13/90</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>FEB 15 1990</i>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Jake Davidson-Randall</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Donald Eugene CRAMPTON</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH <i>2</i> DAY <i>12</i> YEAR <i>1990</i>   |  | 3. TIME OF DEATH<br><i>0630</i> M  |   |
| 4. SOCIAL SECURITY NUMBER<br><i>218-34-4105</i>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>54</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>Oct. 20, 1935</i>  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Maryland</i>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Frederick Memorial Hospital</i>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Frederick</i>  |   |
| 9c. COUNTY OF DEATH<br><i>Frederick</i>   |  |  |  | 10a. STATE<br><i>Maryland</i>   |  | 10b. COUNTY<br><i>Frederick</i>  |   |
| 10c. CITY, TOWN OR LOCATION<br><i>New Market</i>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><i>General Delivery</i>  |   |
| 10f. ZIP CODE<br><i>21774</i>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>Black</i>  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>7</i> College (1-4 or 5+) <i></i>   |  |  |  | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Cook</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Hotel</i>   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Clamon G. Crampton</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Winifred Hammond</i>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Betty Jane Crampton</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>45 E 5th St., Frederick, Md. 21701</i>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i></i>   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Simpson Cemetery</i>   |  | 20c. LOCATION — City or Town, State<br><i>New Market, Md.</i>  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Olin L. Molesworth</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Olin L. Molesworth, P.A.<br/>26401 Ridge Rd., Damascus, Md. 20872</i>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Carcinoma metastatic primary colon cancer</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><i>Malignant cachexia</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide |  |  |   |
| 28a. DATE OF INJURY (Month, Day, Year)  |  |  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28c. DESCRIBE HOW INJURY OCCURRED  |   |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Nicholas P. Foris</i>   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>2/12/90</i>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Nicholas P. Foris 915 Tollhouse on E. Frederick</i>   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><i>FEB 14 1990</i>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rodell</i>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>STEVEN BRETT CERSLEY  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>2-20-90   |  | 3. TIME OF DEATH<br>9:55AM  |  |
| 4. SOCIAL SECURITY NUMBER<br>218-94-8963  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>22 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>12/23/1967   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>FOUND: Field at Corina Drive  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Highland   |  | 9c. COUNTY OF DEATH<br>Howard County  |  |
| 10a. STATE<br>MD.   |  |   |  | 10b. COUNTY<br>Howard   |  | 10c. CITY, TOWN OR LOCATION<br>Highland   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br>6726 Montell Court  |  |   |  |
| 10f. ZIP CODE<br>20777  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>was not employed                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>n/a   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Walter Cersley   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Celeste Bierly   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Celeste Cersley   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8839 Seeker's Walk, Walkersville, Md. 21793  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Resthaven Cemetery  |  | 20c. LOCATION — City or Town, State<br>Frederick, Md.   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Hande L Lemmer   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>1621 Opossumtown Pike<br>Frederick, Maryland 21701  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hanging<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)<br>UNKNOWN   |  | 28b. TIME OF INJURY<br>UKN. M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br>Subject hanged self  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>Field in tree   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>Field at Corina Drive, Howard County, Maryland  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Margarita A. Korell  |  |   |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>2-21-90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARGARITA A. KORELL, MD 111 Penn Street, Baltimore, MD 21201 vc  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 22 1990  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |  |   |  |
|--|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Catherine Geisbert Cramer  |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 28, 1990   |  | 3. TIME OF DEATH<br>7:15 p M  |  |
| 4. SOCIAL SECURITY NUMBER<br>212-24-5696   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>81 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Dec. 23, 1908   |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Citizens Nursing Home of Fred. Co.   |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick  |  | 9c. COUNTY OF DEATH<br>Frederick  |  |
| RESIDENCE OF DECEDENT  |  |  |   |   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Frederick   |   | 10c. CITY, TOWN OR LOCATION<br>Frederick  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>1421 Taney Avenue  |  |  |   | 10f. ZIP CODE<br>21701  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>11  |  |  |   | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Secretarial  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Distributor/ Hotel  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Charles Gilds Gesibert  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Sarah Eliza Snouffer   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mr. James J. Cramer  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Rt. 3, Box 125, Harpers Ferry, W.Va. 25425   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mount Olivet Cemetery  |   | 20c. LOCATION — City or Town, State<br>Frederick, Maryland  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Keith Lynn Robinson</i> M00706   |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>Keeney & Basford PA Funeral Home<br>106 East Church St., Frederick, MD. 21701   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Emphysema</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |   |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE NOW INJURY OCCURRED  |  |  |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |   |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Lloyd E. Halvorson</i>   |  |  |   | 29c. LICENSE NUMBER<br>M 10514  |  | 29d. DATE SIGNED (Month, Day, Year)<br>March 1, 1990  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Lloyd E. Halvorson, MD., 1475 Taney Avenue, Frederick, Maryland 21701   |  |  |   |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 01 1990   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |   |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 may be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Curtis Cora E. CORA E. CURTIS</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH <i>3</i> DAY <i>15</i> YEAR <i>90</i>   |  | 3. TIME OF DEATH<br><i>1227</i> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>265-12-1362</i>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>81</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>10/15/08</i>   |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><i>Washington Adventist Hospital</i>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Takoma Park, MD</i>   |  | 9c. COUNTY OF DEATH<br><i>Montgomery</i>  |  |
| 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Montgomery</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>Spencerville</i>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>1401 Parrsridge Drive</i>   |  |  |  | 10f. ZIP CODE<br><i>20868</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>White</i>                          |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>YEARS.</i>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Homemaker</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>AT Home</i>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Ross</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Luthey</i>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>David Curtis</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1401 Parrsridge Dr. Spencerville, MD 20668</i>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Cronco Crematory</i>  |  | 20c. LOCATION — City or Town, State<br><i>Elyria, Ohio</i>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Kendall Burney Vancil</i><br>KENDALL BURNEY VANCIL   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>TAKOMA FUNERAL HOME, INC.</i><br><i>254 Carroll St. N.W. Washington DC</i>   |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cerebrovascular Accident</i>  |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF): <i>36</i>   |  |  |  |   |  |   |  |
| b. <i>Arrhythmia</i>   |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF): <i>72</i>   |  |  |  |   |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><i>NA</i>  |  | 28b. TIME OF INJURY<br><i>NA</i> M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><i>NA</i>   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><i>NA</i>   |  |   |  |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Dr. David Curtis</i>   |  |  |  | 29c. LICENSE NUMBER<br><i>D 22846</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>3/15/90</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>ROBERT DIBIANCO MD, WASH. ADVENTIST HOSP. TAKOMA PARK MD</i>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>MAR 19 '90</i>   |  | 32. REGISTRAR'S SIGNATURE<br><i>J. Davidson-Randall</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Margaret Ann Collins</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-9-90</b>   |  | 3. TIME OF DEATH<br><b>11:56 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>577-24-6973</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>69 YRS.</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9-30-20</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Holy Cross Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>2605 Glen Allen Ave., Apt. 101</b>   |  |  |  | 10f. ZIP CODE<br><b>20906</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>1</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>SECRETARY</b>               |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>FEDERAL AVIATION AGENCY</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>GEORGE F. JONES</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CATHERINE A. BARRETT</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print) (SISTER-IN-LAW)<br><b>ELIZABETH C. JONES</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2713 HENDERSON AVENUE, WHEATON, MARYLAND 20902</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MOUNT OLIVET</b>  |  | 20c. LOCATION — City or Town, State<br><b>WASHINGTON, D.C.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert Hachary</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W., SIL. SP., MD 20901</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. myocardial infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Arteriosclerotic Cardiovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate interval Between Onset and Death<br><b>minutes</b><br><b>years</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>3/4</b>   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|   |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Deputy Medical Examiner</b><br><b>Paul A. DeVore</b>   |  | 29c. LICENSE NUMBER<br><b>DO 1852</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-10-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>PAUL A. DEVORE MD 4203 Queensbury Rd Hyattsville MD 20781</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 16 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson Randall</b>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21201-146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician. The burial-transit permit, Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.


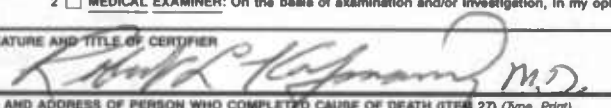

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ELIZABETH CONELLY</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>02</b> DAY <b>16</b> YEAR <b>1990</b>   |  | 3. TIME OF DEATH<br><b>10:47 A.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>181-14-7491</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>93</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9/14/1896</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>  |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>  |  |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |  |  |
| 10a. STATE<br><b>PA</b>   |  | 10b. COUNTY<br><b>Fayette</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Brownsville</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO            |  |
| 10e. STREET AND NUMBER<br><b>625 High Street</b>  |  |  |  | 10f. ZIP CODE<br><b>15417</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b><br>College (1-4 or 5+) <b>College</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James Dunn</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elizabeth Almond</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Jean Gilmore</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>305 W. Ridge Circle Mt. Airy, MD 21771</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Bridgeport Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Brownsville, PA</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, PA<br/>1201 N. Market St. Frederick, MD 21701</b>   |  |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Coronary Heart Failure</b>   |  |  |  |  |  |  |  |
| a. <b>Due to (or as a consequence of):</b>  |  |  |  |  |  |  |  |
| b. <b>Due to (or as a consequence of):</b>  |  |  |  |  |  |  |  |
| c. <b>Due to (or as a consequence of):</b>  |  |  |  |  |  |  |  |
| d. <b>Due to (or as a consequence of):</b>  |  |  |  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>ROBERT L. KAUFMANN, M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D13971</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>February 16, 1990</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)<br><b>ROBERT L. KAUFMANN, M.D. 300 West 9th Street Frederick, Maryland 21701</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 16 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Ruth Naomi Cornelison</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH <i>2</i> DAY <i>15</i> YEAR <i>1990</i>  |  | 3. TIME OF DEATH<br><i>7:36A.</i> M  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>485-62-9115</i>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>68</i> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>March 14, 1921</i>  |  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Iowa</i>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Frederick Memorial Hospital</i>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Frederick, Maryland</i>  |  |  |
| 9c. COUNTY OF DEATH<br><i>Frederick</i>   |  |  |  | 10a. STATE<br><i>Md.</i>   |  | 10b. COUNTY<br><i>Frederick</i>  |  |  |
| 10c. CITY, TOWN OR LOCATION<br><i>Frederick</i>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><i>1421 Taney Avenue</i>   |  |  |
| 10f. ZIP CODE<br><i>21701</i>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>white</i>   |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>College (1-4 or 5+)</i>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Police Matron</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>City Police</i>   |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>William Andrew Brooker</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Blanch Long</i>  |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Gary Cornelison</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>11916 Lynn Crest Rd., Monrovia, Md. 21770</i>  |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Evergreen Cemetery</i>  |  | 20c. LOCATION — City or Town, State<br><i>Red Oak, Iowa</i>  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Sharon Camille Cline</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Stauffer Funeral Home<br/>1621 Opossumtown Pike, Frederick Md.</i>  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>COPD</i><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. <i>21701</i><br>Approximate Interval Between Onset and Death<br><i>years</i> |  |  |  |  |  |  | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Neil J. Calkin</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>D26516</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>2/15/90</i>  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>1475 Taney Ave Frederick MD 21701</i>   |  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>FEB 20 1990</i>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Guliy Davidson-Randall</i>   |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CORA FRANCES HILL CARROLL</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>4</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>1542</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-16-0747</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9/26/1919</b>                              |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>  |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 8c. COUNTY OF DEATH<br><b>Frederick</b>  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |  |
| 10a. STATE<br><b>Md.</b>  |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Adamstown</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>3125 Flinthill Road</b>  |  |  |  | 10f. ZIP CODE<br><b>21710</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>              |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>head cook</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Claggett Center</b>                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Keefer Augustus Hill</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Della Bowie</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Verla Carter</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>40 E. Third St., Frederick, MD. 21701</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Hope Hill U. M. Cem. Frederick, Md.</b>  |  | 20c. LOCATION — City or Town, State  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Handa L. Lemmer</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Stauffer Funeral Home<br/>1621 Opossumtown Pike, Frederick, MD.</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Hypocholesterolemia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Gastric outlet obstruction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. Extensive cervical carcinoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  |  |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  | 29c. LICENSE NUMBER<br><b>D14C 2C</b>  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>2/5/90</b>  |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DRG TRUS-L MD 501 W 52nd St Frederick MD</b>  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 05 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 08868

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Arthur Dickson Catlin</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>February 28, 1990</i>   |  | 3. TIME OF DEATH<br><i>7:00 A.M.</i>   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>042-07-9576</i>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>80</i> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>April 8, 1909</i>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Maryland</i>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>221 S. Jefferson Street</i>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Frederick</i>  |  |
| 9c. COUNTY OF DEATH<br><i>Frederick</i>  |  |  |  | 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Frederick</i>  |  |
| 10c. CITY, TOWN OR LOCATION<br><i>Frederick</i>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 10e. STREET AND NUMBER<br><i>221 S. Jefferson Street</i>   |  |
| 10f. ZIP CODE<br><i>21701</i>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>white</i>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Space Manager</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Federal Government</i>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Levelyn Catlin</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Anna Dickson</i>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Ruth Connoley</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>7600 Irongate Lane, Frederick, Maryland 21701</i>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Epiphany Episcopal Church Cem.</i>  |  | 20c. LOCATION — City or Town, State<br><i>Forrestville, Md.</i>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Darou Camille Cline</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Stauffer Funeral Home<br/>1621 Opossumtown Pike, Frederick, Md. 21701</i>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |  |  |  |  |
| a. <i>Pneumonia</i><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| b. <i>Aortic stenosis</i><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| c. <i>Ⓛ parietal - Ⓡ temporo occipital CVA</i><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| d.   |  |  |  |  |  |  |  |
| Approximate Interval Between Onset and Death<br><i>2 wks.</i><br><i>years</i><br><i>7/89.</i>  |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Hypertension</i><br><i>Renal artery stenosis</i>  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  |
| 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>M. H. Schmidt</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>D36701</i>   |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><i>3-1-90</i>   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |
| 31. DATE FILED (Month, Day, Year)  |  |  |  | 32. REGISTRAR'S SIGNATURE  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Mary Brewer Crabill  |  |  |  | 2. DATE OF DEATH<br>MONTH 02 DAY 16 YEAR 1990   |  | 3. TIME OF DEATH<br>8:49 A.M.   |   |
| 4. SOCIAL SECURITY NUMBER<br>217-48-2916   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br>101 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>08/10/1888   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>110 West "C" Street  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Brunswick   |  |   |  | 9c. COUNTY OF DEATH<br>Frederick  |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |   |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Frederick   |  | 10c. CITY, TOWN OR LOCATION<br>Brunswick  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>110 West "C" Street  |  |  |  | 10f. ZIP CODE<br>21716  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Housewife   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Homemaker   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Walper Granville Musgrove   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Indiana Short  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Louise C. Yourtee  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1343 W. Baltimore - Apt A-209, Media, PA 19063   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Burkittsville Union Cemetery   |  | 20c. LOCATION — City or Town, State<br>Burkittsville, MD  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Barbara A. Williams, Funeral Dir.   |  | 22. NAME AND ADDRESS OF FACILITY<br>John T. Williams Funeral Home<br>100 Petersville Rd., Brunswick, MD 21716  |  |   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. Pulmonary Edema<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   | Approximate Interval Between Onset and Death<br>10 hrs. |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | b. Arteriosclerotic C-V Disease<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   | 30 yrs.   |
|  |  | c. Cricopharyngeal Neuromuscular Dysphagia<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   | 3 weeks   |
|  |  | d.   |  |   |  |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |   |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|  |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  |   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>C. T. Byron Kao, M.D.   |  | 29c. LICENSE NUMBER<br>D05834   |  | 29d. DATE SIGNED (Month, Day, Year)<br>Feb. 17, 1990  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>C. T. Byron Kao, M.D., 5 Gum Spring Road, Brunswick, Md. 21716  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>FEB 26 1990   |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Charles Francis Clark</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>20</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>0504</b> M   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>222-16-6848</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>59</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>6-7-1930</b>                            |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>delaware</b>   |  |  |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br><b>ELKTON</b>  |  | 9c. COUNTY OF DEATH<br><b>CECIL</b>   |   |
| 10a. FACILITY NAME (If not institution, give street and number)<br><b>UNION HOSPITAL</b>  |  |  |  | 10b. COUNTY<br><b>CECIL</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>EARLVILLE</b>                                   |   |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>21 VEAZEY COVE ROAD</b>   |  | 10f. ZIP CODE<br><b>21919</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                       |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>KOREA</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>           |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>UNKNOWN</b><br>College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>FARM MANAGER</b>  |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>FARMING</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>FRENCH G. CLARK</b>   |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>FRANCES ?</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>DOLORES T. CLARK</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>21 VEAZEY COVE RD. EARLVILLE, MD 21919</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CLAIRVAUX FARM</b>  |  | 20c. LOCATION — City or Town, State<br><b>EARLVILLE, MD</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSER<br><i>Robert J. [Signature]</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>R.T. BOARD FUNERAL HOME<br/>CHESAPEAKE CITY, MARYLAND</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardio-Pulmonary arrest</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF): <b>ac. Myocardial infarction</b><br>b. DUE TO (OR AS A CONSEQUENCE OF): <b>Coronary vascular accident</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)      |   |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Ernesto Abiang MD</b>   |
| 29c. LICENSE NUMBER<br><b>D04794</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/20/90</b>  |  |   |  |   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 21 90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Georgia Criss</u>  |  |  |  | 2. DATE OF DEATH<br>MONTH <u>3</u> DAY <u>25</u> YEAR <u>90</u>   |  | 3. TIME OF DEATH<br><u>11:45 AM</u>   |  |
| 4. SOCIAL SECURITY NUMBER<br><u>216207457</u>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><u>94</u> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>May 12, 1895</u>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><u>Harford Memorial Hosp.</u>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Harford</u>   |  | 9c. COUNTY OF DEATH<br><u>Harford</u>   |  |
| 10a. STATE<br><u>Maryland</u>   |  | 10b. COUNTY<br><u>Harford</u>  |  | 10c. CITY, TOWN OR LOCATION<br><u>Street</u>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><u>1704 Davis Corner Road</u>   |  |  |  | 10f. ZIP CODE<br><u>21154</u>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><u>White</u>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>6</u><br>College (1-4 or 5+) <u>College</u>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>Housewife</u>                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>---</u>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>Romey --- Pritt</u>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Martha --- Cullip</u>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Manford G. Criss</u>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>2113 Whitehouse Road, Bel Air, Maryland 21014</u>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Bel Air Memorial Gardens</u>  |  | 20c. LOCATION — City or Town, State<br><u>Bel Air, Md.</u>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Howard K. McComas III</u>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>Howard K. McComas III Funeral Home, P.A.<br/>1317 Cokesbury Road, Abingdon, Md. 21009</u>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>dehydration acute renal failure</u><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <u>dehydration x malnutrition</u><br>b. <u>dehydration</u><br>c. <u>malnutrition</u><br>d. <u>congestive heart failure, drug toxicity</u><br><u>organic brain syndrome</u> |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |   |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>How Sam Kim, MD</u>  |  |   |  |   |  |
| 29c. LICENSE NUMBER<br><u>D37364</u>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>3/25/90</u>  |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>Union MEDICAL CLINIC 319 S. Union Ave, HdG, MD 21078.</u>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><u>MAR 27 '90</u>  |  | 32. REGISTRAR'S SIGNATURE<br><u>Gelia Davidson-Randall</u>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Howard Lee CHANEY</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>3</b> - DAY <b>12</b> - YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>11:45 P.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216 - 07 - 8725</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>86</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>March 4, 1904</b>               |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>Greater Laurel-Beltsville Hospital</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Laurel</b>  |  | 9c. COUNTY OF DEATH<br><b>Prince George</b>                                  |  |
| 10a. STATE<br><b>Maryland</b>   |  |   |  | 10b. COUNTY<br><b>Prince George</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Laurel</b>                                 |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br><b>204 10th Street</b>  |  |  |  |
| 10f. ZIP CODE<br><b>20707</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Grade 4</b><br>College (14 or 5+) <b>College (14 or 5+)</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Boiler Operator</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Mineral Pigments Company</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Sam Chaney</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Alice Whitehead</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Donald Chaney</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>204 10th Street Laurel, Maryland 20707</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Meadowridge Memorial Park</b>  |  | 20c. LOCATION — City or Town, State<br><b>Dorsey, Maryland</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Donald Chaney</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Donaldson Funeral Home P.A.<br/>313 Talbott Ave. Laurel, Maryland 20707</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Myocardial Infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Arteriosclerotic cerebrovascular disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Coronary Heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL:<br><input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER:<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Arthur A. Warner MD</i>  |
| 29c. LICENSE NUMBER<br><b>M D13516</b>  |  |   |  |   |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-13-90</b>  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>W A Warner 301 Prince George St Laurel, MD 20707</b>  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 14 '90</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mary M Carlos</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>14</b> YEAR <b>1990</b>   |  | 3. TIME OF DEATH<br><b>2:10 P.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-09-5650</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10-15-06</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Howard County Hospital</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Columbia, Md.</b>   |  | 9c. COUNTY OF DEATH<br><b>Howard</b>  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Howard</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Ellicott City</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>3622 Valley Road</b>   |  |   |  | 10f. ZIP CODE<br><b>21043</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0-12</b><br>College (1-4 or 5+) <b>Typist</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Typist</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Western Union</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Patrick J. Carlos</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Kate E. Kerrigan</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Thomas Coppinger</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3622 Valley Rd., Ellicott City, Md., 21043</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>New Cathedral</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Md.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Harry H. Witzke</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HARRY H. WITZKE FUNERAL HOME</b><br><b>4112 Columbia Rd., Ellicott City, Md. 21043</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Chronic Renal Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Renal Failure</b>  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Frank Maurer MD</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D29909</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/15/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 16 '90</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Greta Davidson-Randall</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3 14 1990 5 109  
10-K-06 Maryland

Mary A Carlos  
213-09-2650 X 83

Howard County Hospital

Columbia, Md.

Howard

Maryland Howard

Ellicott City

X

3622 Valley Road

21043

U.S.A.

X

X

X

White

0-12

Typist

Western Union

Patrick J. Carlos

Kate E. Kerrigan

Thomas Gopfinger

3622 Valley Rd., Ellicott City, Md., 21043

X

New Cathedral

Baltimore, Md.

HARRY H. WITZKE FUNERAL HOME

21 11 11

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Lorraine Chambers</i>   |  |   |  | 2. DATE OF DEATH<br>MONTH <i>03</i> DAY <i>18</i> YEAR <i>90</i>  |  | 3. TIME OF DEATH<br><i>1016 P M</i>   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>234-01-8527</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><i>82</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>MAR. 1, 1908</i>                                      |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>WEST VIRGINIA</i>   |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Shadel Grove Adventist Hospital</i>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Rockville, Md.</i>                                    |  |
| 9c. COUNTY OF DEATH<br><i>Montgomery</i>   |  |   |  | RESIDENCE OF DECEDENT   |  |   |  |
| 10a. STATE<br><i>WV</i>  |  | 10b. COUNTY<br><i>BERKELEY</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>MARTINSBURG</i>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>910 FLORIDA AVENUE</i>  |  |   |  | 10f. ZIP CODE<br><i>25401</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>WHITE</i>                      |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i><br>College (1-4 or 5+) <i>3</i>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>CASHIER &amp; OFFICE MANAGER</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>J.J. NEWBERRY CO (RETAIL)</i>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>BOYD WASHINGTON CHAMBERS</i>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>FANNIE MARGERY SCHELL</i>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>MRS. MAZEANNA CASTLEMAN</i>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>100 N. VALLEY STREET, MARTINSBURG, WV 25401</i>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>ROSEDALE CEMETERY</i>  |  | 20c. LOCATION — City or Town, State<br><i>MARTINSBURG, WV 25401</i>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charles M Brown</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>BROWN FUNERAL HOME, 327 W. KING ST.<br/>PO BOX 821, MARTINSBURG, WV 25401</i>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |   | Approximate Interval Between Onset and Death   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardio respiratory Arrest</i>   |  |   |  |   |  |   | <i>0</i>   |
| a. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |   |  |
| b. <i>Myo cardial Infarction</i>   |  |   |  |   |  |   | <i>12 hrs</i>  |
| c. <i>Digoxin Toxicity</i>   |  |   |  |   |  |   | <i>12 hrs</i>  |
| d. <i>After stroke Cardiovascular Disease</i>  |  |   |  |   |  |   | <i>4 yrs</i>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28. PLACE OF DEATH (Check only one)   |  |   |  |   |  |
|  |  | HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
|  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Edmund J. Devine</i>   |  |   |  | 29c. LICENSE NUMBER<br><i>033677</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>3/19/90</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Edward J Devine, MD 19721 Executive Park Circle Gaithersburg MD</i>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)  |  | 32. REGISTRAR'S SIGNATURE<br><i>20834</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Elbert L. Carroll</u>   |  |  |  | 2. DATE OF DEATH<br>MONTH <u>03</u> DAY <u>10</u> YEAR <u>1990</u>  |  | 3. TIME OF DEATH<br><u>11:55 AM</u>  |  |
| 4. SOCIAL SECURITY NUMBER<br><u>222-05-3601</u>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><u>84</u> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>09-23-05</u>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><u>Maryland</u>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><u>Sinai Hospital</u>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Baltimore</u>  |  |
| 9c. COUNTY OF DEATH<br><u>Baltimore City</u>   |  |  |  | 10a. STATE<br><u>Maryland</u>   |  | 10b. COUNTY<br><u>Carroll</u>  |  |
| 10c. CITY, TOWN OR LOCATION<br><u>Sykesville</u>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><u>6922 Hollenberry Road</u>   |  |
| 10f. ZIP CODE<br><u>21784</u>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <u>Black</u>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>6</u> College (1-4 or 5+) <u></u>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>Laborer</u>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Agriculture</u>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>Elbert L. Carroll</u>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Viola ?</u>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Debra C. Fadiran</u>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>P.O. Box 7713 Baltimore, MD 21221</u>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Lake View Cemetery</u>   |  | 20c. LOCATION — City or Town, State<br><u>Sykesville, MD</u>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Brian L. Haight</u>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>Haight Funeral Home (PO BOX 195)<br/>Sykesville, MD 21784</u>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>PNEUMONIA</u><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. <u>DEMENTIA</u><br>c. <u></u><br>d. <u></u> |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>CHRONIC RENAL FAILURE</u><br><u>MYOCARDIAL INFARCTION</u><br><u>OLD CVA</u>   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Swati Desai, HOUSE-STAFF</u>   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>03/10/90</u>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>SWATI DESAI, SINAI HOSPITAL OF BALTIMORE, MD 21215</u>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><u>MAR 19 '90</u>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNIVERSITY OF CHICAGO

90 08876

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last) <b>HELEN B. CRANE</b>   |  |  |  | 2. DATE OF DEATH <b>MAR. 15, 1990</b>   |  | 3. TIME OF DEATH <b>2:22 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>225-10-3591</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JULY 10, 1912</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>HOLY CROSS HOSPITAL</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SILVER SPRING</b>   |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |  |
| 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>MONTGOMERY</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>SILVER SPRING</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>512 BONIFANT ST.</b>  |  |  |  | 10f. ZIP CODE<br><b>20910</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>ADMINISTRATIVE ASST.</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>RAYO VAC CO.</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>MELVIN BEASLEY</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ELIZABETH CARTER</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>RONALD CRANE</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>SAME AS ITEM #10</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CHAMBERS CREMATORY</b>  |  | 20c. LOCATION — City or Town, State<br><b>RIVERDALE, MD.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>W. W. Chambers</i> <b>M00091</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SILVER SPRING, MD.</b><br><b>W. W. CHAMBERS CO. INC. 20910</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>METASTATIC ADENOCARCINOMA OF UNKNOWN</b><br>DUE TO (OR AS A CONSEQUENCE OF): <b>PRIMARY SITE</b>   |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>2 MOS</b>  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>James A. Brown MD</i>  |  | 29c. LICENSE NUMBER<br><b>007285</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/15/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JAMES A. BROWN, MD 14808 PHYSICIANS LANE ROCKVILLE, MD 20850</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 19 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>G. Davidson</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

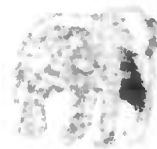
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death, and that it be signed by the attending physician and completely filled in by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Loretta Jean Denney</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 24, 1990</b>   |  | 3. TIME OF DEATH<br><b>0731</b> M   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>234-46-5429</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><b>54</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 2, 1935</b>   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Union Hospital of Cecil County</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Elkton</b>  |  | 9c. COUNTY OF DEATH<br><b>Cecil</b>   |   |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Cecil</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Elkton</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>61 Dixon Lane</b>   |  |  |  | 10f. ZIP CODE<br><b>21921</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                          |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>11</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Dave Campbell</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lora Agnes Justice</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Henry T. Denney</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>61 Dixon Lane Elkton, MD 21921</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gilpin Manor Memorial Park</b>  |  | 20c. LOCATION — City or Town, State<br><b>Elkton, Maryland</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>David J. Hicks</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hicks Home for Funerals, P.A.<br/>Bow and Stockton Streets<br/>Elkton, MD 21921</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Septicemia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <b>Myocardial Infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Advanced Rheumatoid Arthritis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Jui-Chih Hsu, M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>PO 4023</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/26/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Jui-Chih Hsu, M.D. 223 West Main Street Elkton, MD 21921</b>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 26 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 08878

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Ruth Lillian Chambers Diggs</i>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>Jan. 10 90</i>   |  | 3. TIME OF DEATH<br>HOURS MIN. SEC. AM/PM<br><i>5:00 A M</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>218-24-9542</i>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><i>73</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>Nov. 7, 1916</i>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Pennsylvania</i>  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Washington County Hospital</i>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Hagerstown</i>  |  |
| 9c. COUNTY OF DEATH<br><i>Washington</i>   |  |   |  | RESIDENCE OF DECEDENT   |  |   |  |
| 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Frederick</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>Frederick</i>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>1421 Taney Avenue</i>   |  |   |  | 10f. ZIP CODE<br><i>21701</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>Black</i>                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Unknown</i>                      |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Joseph Chambers</i>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Mazie (Unknown)</i>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>William Diggs</i>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1420 Ridgeville Blvd, Mt. Airy, Md 21771</i>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Resthaven Memorial Gar.</i>  |  | 20c. LOCATION — City or Town, State<br><i>Frederick, Md.</i>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Handa L. Lemmer</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Stauffer Funeral Homes, P.A.<br/>P.O. Box 1819, Frederick, MD 21701</i>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>ischemic brain injury</i>   |  |   |  |   |  |   |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>respiratory arrest</i>  |  |   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF): <i>status asthmaticus</i>   |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA                           |  | 26. PLACE OF DEATH (Check only one)<br>OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>HOURS MIN. SEC. AM/PM  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  | 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>R. G. G. G.</i>  |  |   |  | 29c. LICENSE NUMBER<br><i>D32518</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>1-10-90</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>JAN 11 1990</i>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21206

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Richard Donald Davis</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>03</b> DAY <b>23</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>12:17 a.m.</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>216-03-9977</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>02/25/20</b>                                      |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MD</b>   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>1903 Sulaine Court</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Finksburg</b>   |  | 9c. COUNTY OF DEATH<br><b>Carroll</b>   |   |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Carroll</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Finksburg</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO        |   |
| 10e. STREET AND NUMBER<br><b>1903 Sulaine Court</b>   |  | 10f. ZIP CODE<br><b>21048</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>salesman</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>automobile</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Louie H. H. Davis</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Vivian Wilhide</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Nancy Kathryn Davis</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1903 Sulaine Court, Finksburg, MD 21048</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Meadow Branch Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Westminster, MD</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert K. Pritts, Sr.</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Pritts Funeral Home &amp; Chapel<br/>412 Washington Rd. Westminster, MD</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cancer of Lung</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br><b>See Ans</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Spread to involve both lungs</b>   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
|   |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>J. S. [Signature]</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>068029</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/24/90</b>                                       |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J. S. [Signature]</b>   |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 26 90</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |
|--|--|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HAZEL EVELYN DRYDEN</b>   |  | 2. DATE OF DEATH<br>MONTH <b>03</b> DAY <b>23</b> YEAR <b>90</b>  |   | 3. TIME OF DEATH<br><b>3:30p</b> M  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-12-3079</b>  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 8. AGE (In yrs. last birthday)<br><b>86</b> YRS.  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>OCT. 13, 1903</b> |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Southern Maryland Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Clinton</b>   |   | 9c. COUNTY OF DEATH<br><b>Prince Georges</b>  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>PRINCE GEORGE'S</b>   |   | 10c. CITY, TOWN OR LOCATION<br><b>CLINTON</b>   |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>9106 PINEVIEW LANE</b>   |   |   |
| 10f. ZIP CODE<br><b>20735</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6TH GRADE</b><br>College (1-4 or 5+) <b>FARMER</b>  |   |   |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>FARMING</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>FARMING</b>  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>GEORGE WEST</b>  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>SUDIE TYNDEL</b>  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>HENRY G. DRYDEN</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. BOX 1740, OVIEDO, FLORIDA 32765</b>  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>FT. LINCOLN CEMETERY</b>   |   | 20c. LOCATION — City or Town, State<br><b>BRENTWOOD, MARYLAND</b>   |
| 21. SIGNATURE OF FUNERAL SERVICE EXCISEE<br><i>[Signature]</i>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>THE HUNTT FUNERAL HOME, INC.<br/>P.O. BOX 156, WALDORF, MARYLAND 20604-0156</b>  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiopulmonary arrest</i><br>DUE TO (OR AS A CONSEQUENCE OF): <i>Coronary Heart Failure w/ refractory</i><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><i>Acute renal failure</i><br>DUE TO (OR AS A CONSEQUENCE OF): <i>Cardiovascular accident, moment</i><br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Chronic renal insufficiency</i> |  |   |   | Approximate Interval Between Onset and Death  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |   | 28b. TIME OF INJURY<br>M  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |   |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> MD   |  | 29c. LICENSE NUMBER<br><b>D20824</b>  |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/24/90</b>   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John R. (Tolson) 9450 Penn. Ave. #18 Upper Marlboro</b>  |  |   |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 26 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> MD 20712  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Charles Dillon</u>  |  |  |  | 2. DATE OF DEATH<br>MONTH <u>03</u> DAY <u>07</u> YEAR <u>90</u>  |  | 3. TIME OF DEATH<br><u>22:00</u> M  |   |
| 4. SOCIAL SECURITY NUMBER<br><u>183-18-8760</u>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><u>65</u> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><u>8-27-24</u>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><u>Pennsylvania</u>  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><u>St. Agnes Hospital</u>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Baltimore</u>   |  | 9c. COUNTY OF DEATH<br><u>Baltimore</u>   |   |
| 10a. STATE<br><u>Maryland</u>  |  | 10b. COUNTY<br><u>Baltimore</u>  |  | 10c. CITY, TOWN OR LOCATION<br><u>Baltimore</u>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><u>2636 Lehman Street</u>  |  |  |  | 10f. ZIP CODE<br><u>21223</u>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><u>WW II</u>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><u>White</u>                          |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) <u>8</u><br>College (1-4 or 5+) <u>WW II</u>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>Heavy Equipment Oper.</u>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Construction</u>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>A. Joseph Dillon</u>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Rith Baker</u>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Jack L. Dillon</u>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>284 Mengus Mill Rd. Littlestown, Pa. 17340</u>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Saint Ignatius Cemetery</u>   |  | 20c. LOCATION — City or Town, State<br><u>Orrtanna, Pa.</u>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Thomas M. March</u>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>MONAHAN FUNERAL HOME</u><br><u>125 CARLISLE STREET</u><br><u>GAITHERSBURG, PA 20855</u>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |   |  |   |   |
| a. <u>Cardiac arrhythmia / Ischemic heart disease</u>  |  |  |  |   |  |   | <u>2 days</u>   |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |   |
| b. <u>CHF / Respiratory failure</u>  |  |  |  |   |  |   | <u>2 days</u>   |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |   |
| c. <u>Pulmonary edema</u>  |  |  |  |   |  |   | <u>2 days</u>   |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |   |
| d. _____   |  |  |  |   |  |   |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |  |  |   |  |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>MI in 1979 + 1982 / CHF, mild regurg,</u><br><u>COPD</u>  |  |  |  |   |  |   |   |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Ralph Amarel M.D.</u>  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>3/7/90</u>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>RALPH ALHAEL 900 Caton Ave Baltimore 21229</u>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><u>3/7/90 MAR 30 1990</u>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Rodriguez</u>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10000 09

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |  |  |   |  |   |  |  |  |   |  |                                   |  |
|--|--|--|--|---|--|---|--|--|--|---|--|---|--|--|--|---|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ANNA ELLEN DOYLE</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAR. 14, 1990</b>  |  |   |  | 3. TIME OF DEATH<br><b>9:25 A.M.</b>   |  |   |  |   |  |  |  |   |  |                                   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>279-22-4049</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><b>69</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>11-10-1920</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Ohio</b>   |  |  |  |   |  |                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Doctor's Hospital</b>   |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Lanham</b>  |  |  |  |   |  | 9c. COUNTY OF DEATH<br><b>Prince George</b>   |  |  |  |   |  |                                   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |  |  |   |  |   |  |  |  |   |  |                                   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Prince George</b>  |  |   |  | 10c. CITY, TOWN OR LOCATION<br><b>Hyattsville</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |  |  |   |  |                                   |  |
| 10e. STREET AND NUMBER<br><b>5007 Decatur Street</b>   |  |  |  |   |  | 10f. ZIP CODE<br><b>20781</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  |   |  |   |  |  |  |   |  |                                   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |   |  |  |  |   |  |                                   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8 years</b><br>College (1-4 or 5+) <b>College</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Waitress</b>  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Restaurant Industry</b>   |  |   |  |   |  |  |  |   |  |                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James Waltrass</b>   |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary M. Geiger</b>  |  |  |  |   |  |   |  |  |  |   |  |                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Charles E. Doyle</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>same As # 10</b>  |  |   |  |  |  |   |  |   |  |  |  |   |  |                                   |  |
| 20a. MANNER OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Parklawn Cemetery</b>  |  |   |  | 20c. LOCATION — City or Town, State<br><b>Rockville, Maryland</b>  |  |   |  |   |  |  |  |   |  |                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Donald V. Borgwardt</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Borgwardt Funeral Home</b><br><b>4400 Powder Mill Rd. Beltsville, Md. 20705</b>  |  |   |  |  |  |   |  |   |  |  |  |   |  |                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br><b>respiratory failure</b><br><b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b><br><b>minimally</b><br><b>hypertension</b><br><b>chronic alcohol consumption</b> |  |  |  |   |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |  |  |   |  |                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>heart disease</b><br><b>coronary artery disease</b><br><b>atherosclerosis</b>   |  |  |  |   |  |   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Lewis Hilliard Dennis</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>201499</b>   |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/14/90</b>   |  |  |  |   |  |                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Lewis Hilliard Dennis, M.D. 6201 Greenbelt Road, #U-17, College Park, Md. 20740</b>  |  |  |  |   |  |   |  |  |  |   |  |   |  |  |  |   |  |                                   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 16 90</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Lewis Hilliard Dennis</b>   |  |   |  |  |  |   |  |   |  |  |  |   |  |                                   |  |





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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>SADIE MAY DeLAUTER  |  |  |  | 2. DATE OF DEATH<br>MONTH 3 DAY 21 YEAR 90  |  | 3. TIME OF DEATH<br>0210 M   |  |
| 4. SOCIAL SECURITY NUMBER<br>218-30-9842  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>87 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>JAN. 4, 1903  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>WASHINGTON COUNTY HOSPITAL  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>HAGERSTOWN  |  |
| 9c. COUNTY OF DEATH<br>WASHINGTON   |  |  |  | 10a. STATE<br>MARYLAND  |  | 10b. COUNTY<br>FREDERICK   |  |
| 10c. CITY, TOWN OR LOCATION<br>SABILLASVILLE  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>15133 A. FOXVILLE CHURCH RD.   |  |
| 10f. ZIP CODE<br>21780  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE  |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7 College (1-4 or 5+) N/A  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>HOMEMAKER   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>NONE  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>TRACEY HORINE DeLAUTER   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>MINNIE NORA HARBAUGH   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>ROBERT McAfee   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>15133 A. FOXVILLE CHURCH RD. SABILLASVILLE, MD. 21780  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>BURNS HILL CEMETERY   |  |  |  |
| 20c. LOCATION — City or Town, State<br>WAYNESBORO, PA.  |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br>ROBERT E. DAILEY & SON, P.A.<br>615 E. MAIN ST., THURMONT, MD. 21788  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiac arrest</u><br>b. <u>arrhythmic</u><br>c. <u>Myocardial infarction</u><br>d. <u>Anterior MI</u><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Hypertension</u>   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  |  |  | 28b. TIME OF INJURY<br>M  |  |  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  |
| 29c. LICENSE NUMBER<br>D26806   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br>3/21/90  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Allen U. Dittus MD 1610 Oak Hill Ave Hagerstown MD 21740   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 22 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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PA. 71 98  
PA. 71 98

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>ALVIN DUNN, Jr.   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>1-28-90  |  | 3. TIME OF DEATH<br>4:15PM M   |  |
| 4. SOCIAL SECURITY NUMBER<br>436-75-4116  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>YRS. MONTHS DAYS<br>4 30   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Aug. 29, 1989   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Louisiana   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Shady Grove Adventist Hospital   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Rockville   |  |
| 9c. COUNTY OF DEATH<br>Montgomery County  |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Montgomery  |  |
| 10c. CITY, TOWN OR LOCATION<br>Germantown   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>18040 Cottage Garden Dr.   |  |
| 10f. ZIP CODE<br>20874  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES       |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)                                     |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  | 17. FATHER'S NAME (First, Middle, Last)<br>Alvin Dunn, Sr.   |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Sharon Martin  |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br>Alvin Dunn, Sr.  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>18040 Cottage Garden Dr., Germantown, Md. 20874       |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. Olivet Cemetery  |  | 20c. LOCATION — City or Town, State<br>Frederick, Md.  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Olin L. Molesworth  |  |
| 22. NAME AND ADDRESS OF FACILITY<br>Olin L. Molesworth, P.A.<br>26401 Ridge Rd., Damascus, Md. 20872  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sudden Infant Death Syndrome<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  |
| 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Mario F. Golle, Jr., MD   |  |
| 29c. LICENSE NUMBER<br>OCME   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br>1-29-90   |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARIO F. GOLLE, JR., MD 111 Penn Street, Baltimore, MD 21201 vc |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 02 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John A. ...   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Viola Elizabeth Davis</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 16, 1990   |  | 3. TIME OF DEATH<br>10:40 a m   |  |
| 4. SOCIAL SECURITY NUMBER<br>218-64-3258  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>79 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Oct. 15, 1910  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Frederick Memorial Hospital  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick  |  | 9c. COUNTY OF DEATH<br>Frederick  |  |
| 10a. STATE<br>Maryland  |  |  |  | 10b. COUNTY<br>Frederick  |  | 10c. CITY, TOWN OR LOCATION<br>Frederick  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br>8617 Yellow Springs Road  |  |   |  |
| 10f. ZIP CODE<br>21701  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR OATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>6   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Charles Edwin Linton   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Pearl E. Kintz   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Charles E. Davis  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5619 Shookstown Road, Frederick, Maryland 21701  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Pleasant Hill Cemetery   |  | 20c. LOCATION — City or Town, State<br>Frederick, Maryland  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Kathleen Robison</i> M000706  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Keeney & Basford PA Funeral Home<br>106 E. Church Street, Frederick, MD 21701   |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardio pulmonary arrest</i><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <i>acute Myocardial Infarction</i><br>c.<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>K. Basford</i>  |  |  |  | 29c. LICENSE NUMBER<br>D 216 48   |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/19/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Kusny BARAKAT 310 W 9th Street Frederick MD 21701  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 20 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

For the purpose of the

For the purpose of the

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Nita N. Doubroff</i>  |  |   |  | 2. DATE OF DEATH<br>MONTH <i>2</i> DAY <i>8</i> YEAR <i>90</i>  |  | 3. TIME OF DEATH<br><i>11:15 P M</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>577-50-0808</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><i>54</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>3-6-1935</i>                                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>1110 Pinewood Drive</i>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Frederick</i>   |  | 9c. COUNTY OF DEATH<br><i>Frederick</i>   |  |
| 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Frederick</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>Frederick</i>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO        |  |
| 10e. STREET AND NUMBER<br><i>1110 Pinewood Drive</i>   |  |   |  | 10f. ZIP CODE<br><i>21701</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>White</i>                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Housewife</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Own home</i>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Ralph B. Berry</i>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Mary Smith</i>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Jerome Doubroff</i>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1110 Pinewood Drive, Frederick, Md. 21701</i>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Smithsburg Crematory</i>   |  | 20c. LOCATION — City or Town, State<br><i>Smithsburg, Md.</i>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Sharon Camille Cline</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>1621 Opossumtown Pike, Frederick Md. 21701</i>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>EXTENSIVE PULMONARY</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
|  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  | 29c. LICENSE NUMBER<br><i>014622</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>3/9/90</i>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>PG Rogers MD 501 West Street St Frederick</i>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>FEB 12 1990</i>  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>ERMA MAY DINTERMAN</i>  |  |   |  | 2. DATE OF DEATH<br>MONTH <i>2</i> DAY <i>7</i> YEAR <i>90</i>  |  | 3. TIME OF DEATH<br><i>1025A M</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>215-10-2491</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 8. AGE (In yrs. last birthday)<br><i>88</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>8-28-1901</i>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Frederick Memorial Hospital</i>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Frederick</i>   |  | 9c. COUNTY OF DEATH<br><i>Frederick</i>   |  |   |  |
| 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Frederick</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>Frederick</i>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>500 Military Road</i>   |  |   |  | 10f. ZIP CODE<br><i>21701</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Sewing Machine Operator</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Frederick Tailoring Co.</i>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>William Haugh</i>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Minnie Biser Haugh</i>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>John W. Dinterman</i>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>8016 Fieldstone Dr., Frederick, Maryland 21701</i>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Union Chapel Cemetery</i>  |  | 20c. LOCATION — City or Town, State<br><i>Liberty, Maryland</i>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Marianne H. Stauffer</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Stauffer Funeral Homes, PA<br/>P.O. Box 1819, Frederick, Maryland 21701</i>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiopulmonary Arrest</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>End Stage Cardomyopathy</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>End Stage Renal Insufficiency</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
|  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Edward P. Link MD</i>  |  |   |  | 29c. LICENSE NUMBER<br><i>MD D36649</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>2/7/90</i>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>310 W 9th St Frederick MD 21701</i>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>FEB 08 1990</i>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Jula Davidson-Pondell</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

11:05 A. M.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CHARLES QUINCY DRUMMOND</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>01</b> DAY <b>01</b> YEAR <b>1990</b>  |  | 3. TIME OF DEATH<br><b>1105 A</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>326-24-3933</b>  |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan. 3, 1901</b>                                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>FREDERICK MEMORIAL HOSPITAL</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>FREDERICK</b>   |  | 9c. COUNTY OF DEATH<br><b>FREDERICK</b>   |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>FREDERICK</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>FREDERICK</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>5603 WOODLYN ROAD</b>   |  |   |  | 10f. ZIP CODE<br><b>21701</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>5</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HIGH SCHOOL TEACHER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>WILLIS C. DRUMMOND</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>OLIVE WHEELER</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MRS. MARY D. MORRIS</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5603 WOODLYN ROAD, FREDERICK, MARYLAND 21701</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory</b>   |  | 20c. LOCATION — City or Town, State<br><b>Smithsburg, Maryland</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A.<br/>1201 NORTH MARKET STREET., FRED., MD. 21701</b>   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory depression</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><div style="display: flex; align-items: center;"> <div style="font-size: 3em; margin-right: 10px;">{</div> <div> <b>Syndrom of inappropriate</b><br/>DUE TO (OR AS A CONSEQUENCE OF):<br/><b>ADH secretion</b><br/>DUE TO (OR AS A CONSEQUENCE OF):<br/><b>hypertension</b> </div> </div> |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br><b>7 d</b><br><br><b>10 yrs</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL:<br><input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER:<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |   |  |   |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |   |  | 29c. LICENSE NUMBER<br><b>014622</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/1/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. J. A. Trausch MD 501 West Street Frederick MD</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 3 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1-4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>William F. DeGrange</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>24</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>1658</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-26-1348</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (in yrs. last birthday)<br><b>56</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Dec. 1, 1933</b>                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Frederick</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>58 East South Street</b>  |  |   |  | 10f. ZIP CODE<br><b>21701</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>7</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Taxi Cab Driver</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Transportation</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Harlan William DeGrange</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sadie Marie Hurst</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Tina M. Houck</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8213 Fingerboard Road, Frederick, Maryland 21701</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Union Chapel Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Libertytown, Maryland</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Keith Lynn Robinson</i> MO0706   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney &amp; Basford PA Funeral Home<br/>106 E. Church St., Frederick, MD 21701</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIAC ARREST</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>RENAL FAILURE</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br><b>Arrhythmia Fibrillation</b> |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br><b>30 days</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Arrhythmia Fibrillation</b>   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
|  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>W. R. P.</i> MD  |  |   |  | 29c. LICENSE NUMBER<br><b>D 29591</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/24/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)<br><b>56 Thomas Johnson Dr Frederick MD 21701</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 29 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>   |  |   |  |   |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Russell Allen DUDROW</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 24 1990</b>  |  | 3. TIME OF DEATH<br><b>1215 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-36-2592</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Jan. 27, 1904</b>                                  |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY<br><b>Frederick</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>712 Wyngate Drive</b>  |  |   |  |
| 10f. ZIP CODE<br><b>21701</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>4</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Dairy Farmer</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Farming</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Clarence D. Dudrow</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rosa M. Wachter</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Robert E. Dudrow</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1808 Lawnview Drive, Frederick, Md. 21701</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mount Olivet Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Frederick, Maryland 21701</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Richard C. Bradford</i> M00021   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney and Basford Funeral Home<br/>106 East Church St., Frederick, Md. 21701</b>   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Carcinoma of pancreas</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alzheimer's Disease</b>   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>a <input type="checkbox"/> Pending Investigation b <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Austin Pearre Jr.</i>  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/24/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. A. Austin Pearre, Jr., M.D., 300 West Ninth St., Frederick, Md. 21701</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 24 1990</b>  |  |  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached from the certificate and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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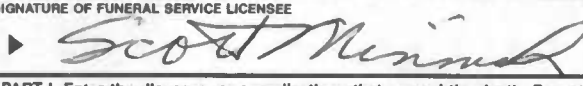


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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |   |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Gertrude Christianna DOERING<br>Gertrude C. Doering   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>January 10 1990  |  | 3. TIME OF DEATH<br>3:59 a M   |   |
| 4. SOCIAL SECURITY NUMBER<br>217-18-8909  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F         |  | 6. AGE (In yrs. last birthday)<br>79 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>March 17, 1910   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Williamsport Nursing Home  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Williamsport  |   |
| 9c. COUNTY OF DEATH<br>Washington   |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Washington  |   |
| 10c. CITY, TOWN OR LOCATION<br>Hagerstown   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>640 Security Road  |   |
| 10f. ZIP CODE<br>21740  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>white  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>teacher's aide  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>public school  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Arthur Roelke  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Edna E. Miller  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Cynthia C. Young  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>648 Security Road, Hagerstown, Maryland 21740   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Rest Haven Cemetery  |  | 20c. LOCATION — City or Town, State<br>Hagerstown, Md.   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>MINNICH FUNERAL HOME<br>415 E. Wilson Blvd., Hagerstown, Md. 21740   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Pneumonia</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. <u>Aspiration</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <u>Cerebral Vascular Accident</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____ |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Carcinoma of the breast</u>  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural a <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide a <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br> MD   |  |  |  | 29c. LICENSE NUMBER<br>D33700  |  | 29d. DATE SIGNED (Month, Day, Year)<br>▶   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Ted E. Howe, MD, 18100 Marden Lane, Olney, MD 20832  |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>JAN 11 '90   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>Ethel Pharby Duling</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 15, 1990</b>   |  | 3. TIME OF DEATH<br><b>10:50 AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-01-8010</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>92</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Feb 24, 1898</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Kent &amp; Queen Anne's Hospital Inc</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Chestertown</b>   |  | 9c. COUNTY OF DEATH<br><b>Kent</b>   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Talbot</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Easton</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>217 N. Locust Street</b>  |  |   |  | 10f. ZIP CODE<br><b>21601</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>unknown</b><br>College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>               |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>unknown</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>unknown</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ellen Ross Coleman</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Chestertown, MD 21620</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Greensboro Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Greensboro, MD</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Gary B. Fellows</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Fellows Funeral Home<br/>P. O. Box 270, Millington, MD 21651</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Colitis C.C.I. difficile</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF): <b>pneumonia</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>3 weeks</b><br><b>4 weeks</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ASCVD, cerebrovascular disease<br/>recent intertrochanteric fracture femur</b>  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>G. G. Baerens</b>  |  |   |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/16/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>C. G. Baerens Medical Bldg. Chestertown, Md</b>  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 19 '90</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>G. Davidson-Randall</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Wilson Downes</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 7, 1990</b>   |  | 3. TIME OF DEATH<br><b>9:00 A.M.</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>221-12-1932</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs., last birthday)<br><b>70</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>6-12-1919</b>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MD</b>  |  |  |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br><b>Easton</b>  |  | 9b. COUNTY OF DEATH<br><b>Talbot</b>  |   |
| 9c. FACILITY NAME (If not institution, give street and number)<br><b>Memorial Hospital</b>   |  |  |  | 10. RESIDENCE OF DECEDENT   |  |   |   |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Caroline</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Greensboro</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>PO Bx 368</b>   |  |  |  | 10f. ZIP CODE<br><b>21639</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                      |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>6 th</b>  |  | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>longshoreman</b>                 |  | 17. KIND OF BUSINESS/INDUSTRY<br><b>Wilmington Port Athor.</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Isaac Downes</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Edith Downes</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Neva Downes</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>PO Bx 368 Greensboro, MD 21639</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Union Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Goldsboro, MD</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Greensboro, MD 21639</b><br><b>Fleegle-Helfenbein Fn Hm PO Bx 160</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>chronic obstructive pulmonary disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>lung cancer</b><br><b>Atrial Fibrillation / Flutter</b>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | HOSPITAL:<br>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA             |  | OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |   |
| 28d. DESCRIBE NOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br><b>D31376</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/7/90</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>James S. Sikes PO Box 660 Denton MD</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 09 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Cecil K. DONALDSON</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 25, 1990</b>   |  | 3. TIME OF DEATH<br><b>8:01A</b> M  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>577-44-1575</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>60</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>May 19, 1929</b>                                   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Washington D.C.</b>  |  |  |  |   |  |   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>AMT DOCTORS' HOSPITAL OF P.G. CO.</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>LANHAM</b>  |  | 9c. COUNTY OF DEATH<br><b>PRINCE GEORGE'S</b>   |   |
| 10a. STATE<br><b>MD.</b>  |  |  |  | 10b. COUNTY<br><b>P.G.</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Berwyn Heights</b>  |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |   |   |
| 10e. STREET AND NUMBER<br><b>8805 60TH. Ave.</b>  |  |  |  | 10f. ZIP CODE<br><b>20740</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) -----   |  |  |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Program Analyst</b>   |  | 16. KIND OF BUSINESS/INDUSTRY<br><b>U.S.D.A.</b>  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Donaldson</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Maude Clark</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Nancy J. Donaldson</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8805 60TH. Ave. Berwyn Heights, MD. 20740</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Chambers Crematory</b>  |  | 20c. LOCATION — City or Town, State<br><b>Riverdale, MD.</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Thomas S. Chambers</i> # 670  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>W.W. Chambers Co. Inc.</b><br><b>5801 Cleveland Ave. Riverdale, MD. 20737</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Cardiac arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Severe coronary artery (ischemic)</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Previous myocardial infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetic Mellitus</b>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>UNK.</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/25/90.</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>S. PUNJA MD DOCTORS HOSPITAL MD</b>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 26 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Galia Davidson-Randall</i>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>LORI Ann DEAN  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3-7-90  |  | 3. TIME OF DEATH<br>9:28PM M   |  |
| 4. SOCIAL SECURITY NUMBER<br>213-04-5424   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>22 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>03-16-67   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Virginia   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>North Arundel Hospital  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Glen Burnie   |  |
| 9c. COUNTY OF DEATH<br>Anne Arundel County   |  |  |  | 10a. STATE<br>MD  |  | 10b. COUNTY<br>Anne Arundel  |  |
| 10c. CITY, TOWN OR LOCATION<br>Annapolis   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>2009 Bay Ridge Avenue  |  |
| 10f. ZIP CODE<br>21403   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Manager  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Retail Sales   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Joe Paul Dean   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Diana Maria Lively   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Joe Paul Dean  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3908 River Club Road, Edgewater, MD 21037  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Lakemont Cemetery   |  | 20c. LOCATION — City or Town, State<br>Davidsonville, MD   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Thomas J. Hardesty</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Hardesty Funeral Home P.A.<br>12 Ridgely Ave., Annapolis, MD  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple injuries<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>e. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>2 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br>3-7-90   |  | 28b. TIME OF INJURY<br>8:15PM  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br>Passenger in auto/auto impact  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>Road   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>Rt. 648/Rt. 3, Anne Arundel Co, MD  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i><br>29c. LICENSE NUMBER<br>OCME<br>29d. DATE SIGNED (Month, Day, Year)<br>3-8-90   |  |  |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>JAMES KAPLAN, MD 111 Penn Street, Baltimore, MD 21201 VC  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 09 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |  |  |   |  |   |  |
|---|--|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>THOMAS E. DAVIS   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 25, 1990  |  |   |  | 3. TIME OF DEATH<br>9:45P M  |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>196 01 9132  |  |  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>76 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>June 4, 1913 PA.   |  | 8. BIRTHPLACE (State or Foreign Country)  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Vet. Adm. Hosp. Perry Point, Md.  |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Perry Point  |  |  |  | 9c. COUNTY OF DEATH<br>Cecil  |  |   |  |
| 10a. STATE<br>Maryland  |  |  |  | 10b. COUNTY<br>Queen Anne  |  |   |  | 10c. CITY, TOWN OR LOCATION<br>Church Hill   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br>Rte # 1 Box # 53 H  |  |  |  |  |  | 10f. ZIP CODE<br>21623  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WW 2  |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: No |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 2 College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Aviator Commerical Pilot  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Oil and Iron Ore Company   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Isaac Davis  |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Elizabeth Davis  |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Nancy L. Bennett (Daughter)   |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box # 86 Chestertown, Md. 21620 |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Md's Eastern Shore Veterans Cem  |  |   |  | 20c. LOCATION — City or Town, State<br>near Hurlock, Md.   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>J. Willis Wells</i>   |  |  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>P.O. Box # 264<br>J. Willis Wells Chestertown, Md/ 21620  |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Atherosclerotic Heart Disease<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. Chronic obstructive pulmonary disease<br>c. Congestive heart failure, resolved |  |  |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Julia Davidson-Randall</i>  |  |  |  | 29c. LICENSE NUMBER<br>MD-042601-E  |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/25/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>BRAD STODDART, VA MEDICAL CENTER, PERRY POINT, MD 21902  |  |  |  |  |  |   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>M.D.<br>FEB 27 '90   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, if not used, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CHARLES DOLDE</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 7, 1990</b>  |  | 3. TIME OF DEATH<br>1 P M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>162 03 4817</b>  |  | 6. SEX <b>Male</b><br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Oct 4 1912</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Magnolia Hall Nursing Center</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Chestertown</b>   |  | 9c. COUNTY OF DEATH<br><b>Kent</b>   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Cecil</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Earleville</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>230 Cherry Grove Road</b>   |  |  |  | 10f. ZIP CODE<br><b>21919</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS <b>Married</b><br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES <b>No</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: <b>No</b> |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b><br>College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Mechanic Auto</b>                         |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Auto Repairs</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Dolde</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Genevieve Styer</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Cavanagh Funeral Home</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>301 S Chester Pike Norwood, Pa. 19074</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holy Cross Cemetery (3/10/90)</b>   |  | 20c. LOCATION — City or Town, State<br><b>Yeadon, Del. Co. Penna</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>J. Willis Wells</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>J. Willis Wells P.O. Box # 264 Chestertown, Md.</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIO pulmonary ARREST</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. <b>BRAIN tumor</b><br>c.<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia, H/o Craniotomy</b>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John C. Arrabal</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>123889</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Mar. 7 1990</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John C. Arrabal, M.D. Chestertown, Md. 21620</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 08 '90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transmittal. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Sister Mary Joseph DEAN  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March 20, 1990  |  |  |  | 3. TIME OF DEATH<br>8:17 p M  |  |
| 4. SOCIAL SECURITY NUMBER<br>577-44-2908   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>54 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Dec. 25, 1935                              |  | 8. BIRTHPLACE (State or Foreign Country)<br>DC  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Villa St. Michael  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Emmitsburg   |  |  |  | 9c. COUNTY OF DEATH<br>Frederick  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |   |  |
| 10a. STATE<br>MD   |  | 10b. COUNTY<br>Frederick   |  | 10c. CITY, TOWN OR LOCATION<br>Emmitsburg   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br>333 S. Seton Ave.  |  |  |  | 10f. ZIP CODE<br>21727  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>5+  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Teacher   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Daughters of Charity                               |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Joseph Spencer Dean   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Eva Audrey Mitchell  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Sister Rosa Daly   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>333 S. Seton Ave., Emmitsburg, MD 21727  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>St. Joseph's   |  |   |  | 20c. LOCATION — City or Town, State<br>Emmitsburg, MD 21727                          |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John M. Shikes</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>210 W. Main St.<br>Emmitsburg, MD 21727-0427  |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <i>Cerebrovascular Accident &amp; Aspiration Pneumonia</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Brain Surgery for</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>Recurrent Malignant Glioblastoma</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
|  |  |  |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Alan Carroll MD</i>  |  |  |  | 29c. LICENSE NUMBER<br>D18705   |  | 29d. DATE SIGNED (Month, Day, Year)<br>March 20, 1990                                |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Alan Carroll, M.D. S. Seton Ave. Emmitsburg, MD 21727   |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>JAN 21 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |   |  |

MAR 21 1990

*Julia Davidson-Randall*

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CLEMENTINA E. DEARCANGELIS</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 21, 1990</b>   |  | 3. TIME OF DEATH<br><b>6:45 A<sup>M</sup></b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-20-6529</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>89 YRS.</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>06-24-1900</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Memorial Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cumberland</b>  |  | 9c. COUNTY OF DEATH<br><b>Allegany</b>  |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>ALLEGANY</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>CUMBERLAND</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>452 Walnut Street</b>  |  |  |  | 10f. ZIP CODE<br><b>21502</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                          |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>dietician</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Hospital</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Valentino Carpentini</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Catherine Mancinelli</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Filomena A. Bender</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Cumberland, MD 21502</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Patricks Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Cumberland, MD</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>James J. Scarpelli</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Scarpelli Funeral Home,<br/>Cumberland, MD 21502</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Pneumonia Rt lung, aspiration</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST {<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cerebrovascular accident</b> |  |  |  |   |  |   | Approximate interval Between Onset and Death |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Robert J. Barrera</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D14865</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-23-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Barrera Memorial Hospital Medical Building, Cumberland, MD 21502</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 23 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. Anderson</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>TIMOTHY ROBERT DENISAC   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>2-26-90   |  | 3. TIME OF DEATH<br>6:20PM M  |  |
| 4. SOCIAL SECURITY NUMBER<br>214-94-4468   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>25 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Nov. 19, 1964   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Maryland Correctional Institute  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown   |  | 9c. COUNTY OF DEATH<br>Washington County  |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |  |
| 10a. STATE<br>Md.  |  | 10b. COUNTY<br>Prince Georges   |  | 10c. CITY, TOWN OR LOCATION<br>Laurel   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>8270 Leishear Dr.  |  |   |  | 10f. ZIP CODE<br>20707  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>laborer  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>general   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Robert J. Denisac   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Louise K. Miller   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Robert J. Denisac  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8270 Leishear Rd., Laurel, Md. 20707   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Resthaven Memorial Gardens  |  | 20c. LOCATION — City or Town, State<br>Frederick, Md.   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Donald B. Thompson</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Donald B. Thompson Funeral Home<br>31 E. Main St., Middletown, Md. 21769  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Hanging<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   | Approximate interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |
|  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) INCARCERATED |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>2-26-90   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>In Prison   |  | 28e. DESCRIBE HOW INJURY OCCURRED<br>Subject hanged self  |  |   |  |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>Maryland Correctional Institute, Hagerstown, Washington County, MD  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Norma Beekun</i>   |  |   |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>2-27-90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARGARITA A. KORELL, MD 111 Penn Street, Baltimore, MD 21201 vc   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 02 1990   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>George Nathan Deihl   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March 10, 1990  |  | 3. TIME OF DEATH<br>2:30 A. M.   |  |
| 4. SOCIAL SECURITY NUMBER<br>217-44-6331  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>48 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>May 29, 1941                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>NIH, THE CLINICAL CENTER  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Bethesda, Maryland   |  | 9c. COUNTY OF DEATH<br>Montgomery  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Montgomery  |  | 10c. CITY, TOWN OR LOCATION<br>Cabin John   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>P.O. Box 26   |  |  |  | 10f. ZIP CODE<br>20818  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>PERSONNEL MANAGEMENT  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>D. GEORGE DEIHL  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>N. JANE NORMAN   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Mary F. Deihl  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Same as above  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>SMITHBURG  |  | 20c. LOCATION — City or Town, State<br>SMITHBURG, MD.   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Will D. Deihl  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>HILTON FUNERAL HOME<br>22111 BENTSVILLE RD., BARNESVILLE, MD  |  |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |  |  |   |  |  |  |
| a. Hepatorenal Syndrome<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| b. Chronic Hepatitis<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| c. Lymphoma<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| d.  |  |  |  |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO     |  |
| 28d. DESCRIBE NOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Alan V. Justus   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-10-90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Type/Print)<br>Wayne Van Dusen<br>9000 Rockville Pike, Bethesda, Maryland 20892  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 12 1990  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |   |  |  |  |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

20000 00

20000 00



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Emidio John D'ORAZIO</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 3, 1990</b>  |  | 3. TIME OF DEATH<br><b>4:21 P.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>164-05-3504</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan. 28, 1905</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>  |  |   |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  |   |  | 10b. COUNTY<br><b>Frederick</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br><b>5747 Charstone Court</b>   |  |  |  |
| 10f. ZIP CODE<br><b>21701</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) <input type="checkbox"/> College (1-4 or 8+) <input checked="" type="checkbox"/> <b>4</b>   |  | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Accountant</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Electric Company</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Donato D'Orazio</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Concetta DiLullo</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Elaine A. Coccagna</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5747 Charstone Court, Frederick, Md. 21701</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holy Cross Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Yeadon, PA.</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Alan H. Ruby</b> 100703  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney &amp; Basford P.A. Funeral Home, 21701<br/>106 East Church Street, Frederick, Md.</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebral aneurysm</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Sepsis</b><br><b>Stroke</b> |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>10 min</b><br><b>1-2 days</b><br><b>1-2 days</b><br><b>1-2 days</b>                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Timothy F. Hickey</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>207711</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/8/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Timothy F. Hickey, M.D., 516 Trail Avenue, Frederick, Md. 21701</b>  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 06 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Rosetta Patterson DUFFIN   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March 5, 1990   |  | 3. TIME OF DEATH<br>8:00 a m  |   |
| 4. SOCIAL SECURITY NUMBER<br>Unknown   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>88 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Jan. 15, 1902                                  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |   |  | 9. CITY, TOWN OR LOCATION OF DEATH<br>Frederick   |  | 10. COUNTY OF DEATH<br>Frederick  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>22 Carver Apartments   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick  |  |   |   |
| 10a. STATE<br>Maryland   |  |   |  | 10b. COUNTY<br>Frederick  |  | 10c. CITY, TOWN OR LOCATION<br>Frederick  |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br>22 Carver Apartments  |  |   |   |
| 10f. ZIP CODE<br>21701   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black                      |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) ?  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Domestic  |  | 16b. KIND OF BUSINESS/INDUSTRY  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Ernest Davis  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Alice Walker   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Alice L. Smith  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>251 West Fifth Street, Frederick, Maryland 21701   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Fairview Cemetery   |  | 20c. LOCATION — City or Town, State<br>Frederick, Maryland  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE (Type/Print)<br><i>Charles E. Hicks III</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>C.E. Hicks, III<br>106 E. Church St., Frederick, MD. 21701  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>arteriosclerotic heart disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)          |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Thomas E. Stone</i> M.D.   |  |   |  | 29c. LICENSE NUMBER<br>D11512   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-6-90   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Thomas E. Stone, M.D., 4 West Third Street, Frederick, Maryland 21701   |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>MAR 08 1990   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Gina Davidson</i>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


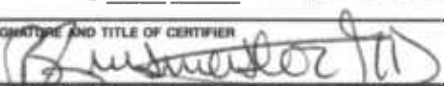
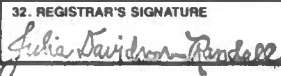
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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>IONE Bellocchio DiGennaro</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 - 16 - 90</b>  |  | 3. TIME OF DEATH<br><b>6:54 p. M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>577-44-8933</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>84 YRS.</b>  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>MARCH 19, 1905</b>                          |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>HOLY CROSS HOSPITAL</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SILVER SPRING</b>   |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |   |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>MONTGOMERY</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>SILVER SPRING</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>11126 NORLEE DRIVE</b>  |  |  |  | 10f. ZIP CODE<br><b>20902</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>               |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>SEAMSTRESS</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>RETAIL CLOTHING</b>  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>GUGLIO BELLOCCHIO</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>LAURA CETRONE</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>LINA DeLEONIBUS (DAUGHTER)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>25 QUINCE MILL COURT, GAITHERSBURG, MARYLAND 20878</b>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ARLINGTON NATIONAL CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>ARLINGTON, VIRGINIA</b>   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W., SIL. SP., MD 20901</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>HEART FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <b>MYOCARDIAL INFARCTION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>CORONARY DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. |  |  |  |   |  |  | Approximate interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
|  |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO     |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)             |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br><b>D24819</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/17/90</b>                                    |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>BRUCE W. ZINSMEISTER, M.D. 8830 CAMERON STREET, #304, SILVER SPRING, MD 20910</b>  |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 22 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |   |  |  |
|---|--|--|---|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>CHRISTINA DELLASANTA  |  |  |   | 2. DATE OF DEATH<br>MONTH 3 - DAY 14 - YEAR 90  |   | 3. TIME OF DEATH<br>4:13 P. M.   |  |
| 4. SOCIAL SECURITY NUMBER<br>027-09-5673  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>86 YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br>JUNE 3, 1903   | 8. BIRTHPLACE (State or Foreign Country)<br>ITALY |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>SUBURBAN HOSPITAL   |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BETHESDA   |   | 9c. COUNTY OF DEATH<br>MONTGOMERY  |  |
| RESIDENCE OF DECEDENT   |  |  |   |   |   |  |  |
| 10a. STATE<br>MASS.   |  | 10b. COUNTY<br>WORCESTER   |   | 10c. CITY, TOWN OR LOCATION<br>WORCESTER  |   | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>200 VERNON STREET   |  |  |   | 10f. ZIP CODE<br>01604  |   | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11th<br>College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>STITCHER                           |   | 16b. KIND OF BUSINESS/INDUSTRY<br>CLOTHING  |   |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>TEFANO FERRI   |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>THERESA PERERINI   |   |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>AOSWALDO DELLASANTA   |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11507 ASHLEY DRIVE, ROCKVILLE, MARYLAND 20852  |   |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>NOTRE DAME CEMETERY  |   | 20c. LOCATION — City or Town, State<br>WORCESTER, MASS.   |   |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael J. Breyer</i>   |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>FRANCIS J. COLLINS FUNERAL HOME, INC.<br>500 UNIVERSITY BLVD., W., SIL. SP., MD 20901   |   |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cerebrovascular Accident</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Coronary artery Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>Hypertension</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <i>Renal failure</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |   |   |   |  | Approximate Interval Between Onset and Death<br>5 days<br>?<br>years<br>?  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Atrial + ventricular arrhythmias</i>   |  |  |   |   |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |   |   |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |   | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |   |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |   | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |   | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |   |   |   |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>D. R. Coe MD.</i>   |  |  |   | 29c. LICENSE NUMBER<br>032193   |   | 29d. DATE SIGNED (Month, Day, Year)<br>3/14/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>6470 ROCKLEDGE DR. SUITE 200 BETHESDA, MD 20817  |  |  |   |   |   |  |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 26 '90   |  |  |   | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |   |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


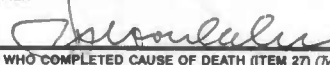
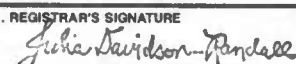
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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Norman Lester ECTON   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March 13, 1990  |  | 3. TIME OF DEATH<br>M   |  |
| 4. SOCIAL SECURITY NUMBER<br>220-10-3755  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>97 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Sep. 18, 1892  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  | 9. COUNTY OF DEATH<br>WASHINGTON  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>3728 Harpers Ferry Rd.  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Sharpsburg,  |  | 9c. COUNTY OF DEATH<br>WASHINGTON   |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Washington   |  | 10c. CITY, TOWN OR LOCATION<br>Sharpsburg   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br>3728 Harpers Ferry Rd.  |  |   |  | 10f. ZIP CODE<br>21782  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Machinist  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Refridgeration Manufacture  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>UNK  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Alice Mae  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>John A. Ecton   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3728 Harpers Ferry Rd. Sharpsburg, MD 21782  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. View Cemetery   |  | 20c. LOCATION — City or Town, State<br>Sharpsburg, MD   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>OSBORNE FUNERAL HOMES<br>P.O. Box # 348 Williamsport, MD 21795  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Autoimmune Heart Disease</u><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  | Approximate Interval Between Onset and Death<br>Yes.  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |   |  | 29c. LICENSE NUMBER<br>D07885   |  | 29d. DATE SIGNED (Month, Day, Year)<br>Mar. 16, 1990  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>John H. Hornbaker, Jr. M.D. 354 Mill St. Hagerstown, MD 21740  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 16 '90   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |   |  |
|--|--|--|--|---|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Fonda F. Euren</b>  |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>7</b> YEAR <b>1990</b>  |   | 3. TIME OF DEATH<br><b>7:15 p</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>295-30-6453</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><b>53</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>4/21/36</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Harford Memorial Hospital</b>   |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Harre de Grace</b>  |   | 9c. COUNTY OF DEATH<br><b>Harford</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |   |   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Kent</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Golts</b>   |  |   |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>Wilson Pt. Road</b>   |  |  |  |   |  | 10f. ZIP CODE<br><b>21637</b>   |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b> |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>UNKNOWN 8</b> College (1-4 or 5+) <b>College</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  |   | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>                           |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Tilford B. Dennison</b>  |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lucy Prine</b>  |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lucinda Euren</b>   |  |  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Box 58A, Wilson Pt. Road, Golts, MD 21637</b> |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Galena</b>   |  |   | 20c. LOCATION — City or Town, State<br><b>Galena</b>                    |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Gary B. Fellows</b>  |  |  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Fellows Funeral Home<br/>370 W. Cypress St, Millington, MD 21651</b>                                       |   |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |   |   |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ventricular fibr. 11th - cardiac arrest</b>   |  |  |  |   |  |   |   |   |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |   |   |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |   |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO           |   |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |   | 28d. DESCRIBE HOW INJURY OCCURED  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>  |  |  |  |   |  | 29c. LICENSE NUMBER   |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/8/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type/Print)<br><b>1604 Churchville Road Bel Air MD 21014</b>  |  |  |  |   |  |   |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 14 90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |   |   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Clementine Marie Elliott</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 01, 1990</b>   |  | 3. TIME OF DEATH<br><b>8:56 AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217 60 5657</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>37</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>3/19/'52</b>                                       |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Physicians Memorial Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>LaPlata</b>   |  | 9c. COUNTY OF DEATH<br><b>Charles</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Charles</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Malcolm</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>Route 3 Box #249</b>  |  |  |  | 10f. ZIP CODE<br><b>20613</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>12th</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Domestic</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Thomas Adams</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Henrietta E. Young</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Marion Hawkins</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6006 Terrell Ave., Forest Hts., MD. 20745</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St Peter's Church Cem</b>   |  | 20c. LOCATION — City or Town, State<br><b>Waldorf, Maryland</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Marion Hawkins</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Adams Funeral Home, P.A.<br/>Aguasco Road, Aguasco, MD. 20608</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>Respiratory arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |
| Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  | b. <b>renal failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | c. <b>Hepatic failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | d.   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> <b>MP</b>  |  | 29c. LICENSE NUMBER<br><b>D-22574</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/2/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Robert Timothy Pace</b><br><b>Post Office Box 249</b><br><b>Waldorf MD, 20604</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 16 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MILFORD LEO EMORY</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 19 1990</b>   |  | 3. TIME OF DEATH<br><b>5:15 PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-18-0696</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><b>75</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>04 10 1914</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Citizen's Nursing Home</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>Rosemont Avenue</b>   |  |  |  | 10f. ZIP CODE<br><b>21701</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Never attended</b><br>College (1-4 or 5+) <b></b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Carpenter's helper</b>      |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Maurice Emory Emory</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Fanny Elizabeth Strausbaugh</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Beatrice E. Hewitt</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10629 Bethel Road, Frederick, Maryland 21701</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory</b>  |  | 20c. LOCATION — City or Town, State<br><b>Smithsburg, Maryland</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert E. Dailey</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Robert E. Dailey &amp; Son Funeral Homes, P.A.<br/>1201 North Market Street, Frederick, Md.</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Renal failure</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>Chronic Nephritis</b><br>b. <b></b><br>c. <b></b><br>d. <b></b> |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>1 week</b><br><b>5y</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alzheimer's Disease</b><br><b>Broncho-Pneumonia</b>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>BO Thomas Jr</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>013409</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>March 20, 1990</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>B. O. Thomas, Jr., M.D., 228 North Market Street, Frederick, Maryland 21701</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 20 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

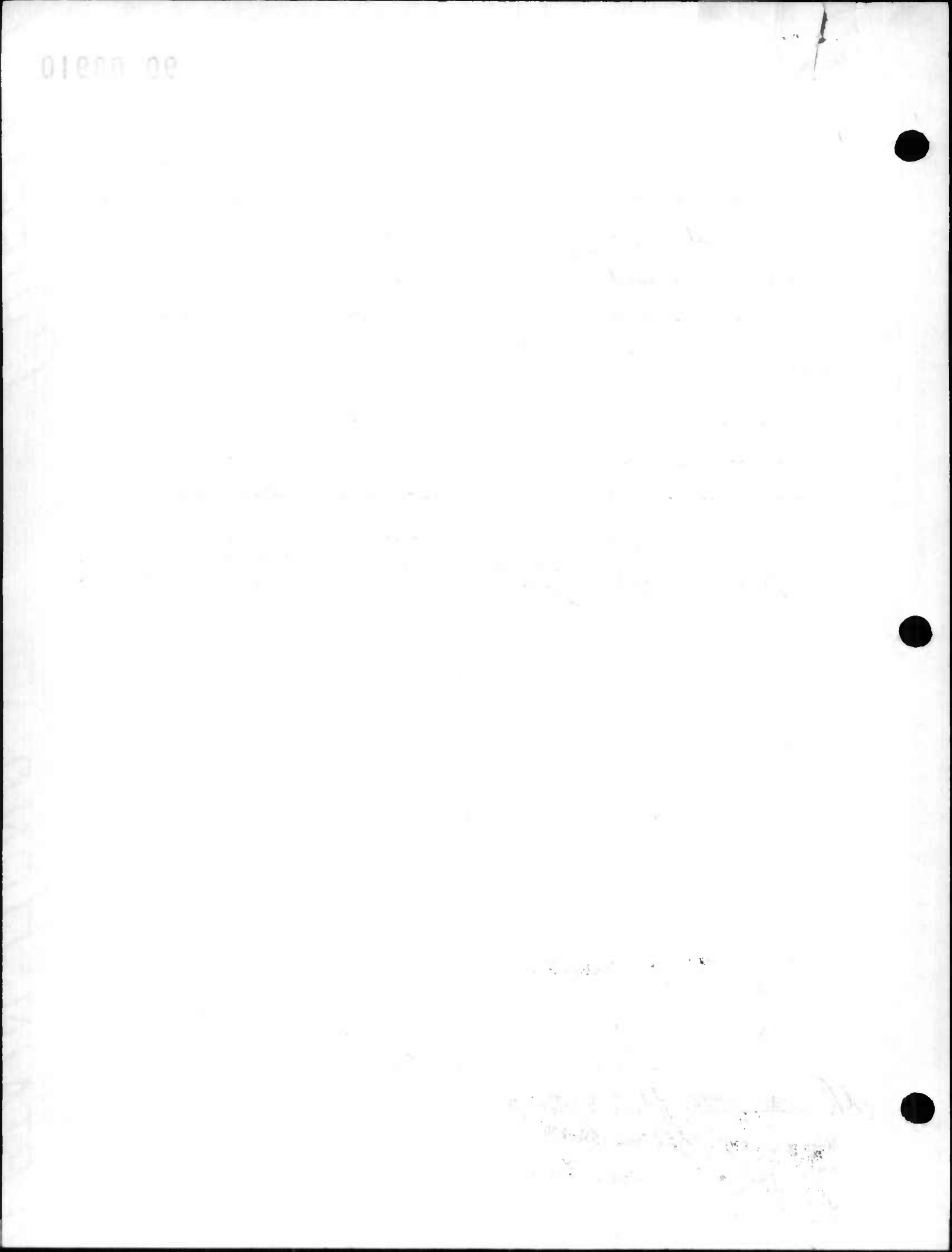
DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MAR 20 1990





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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>KENNETH W. ERNST</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>9</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>12:20A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>204-30-6674</b>  |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><b>80</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug. 14, 1909</b>                                  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Washington Co. Hosp.</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown, Md.</b>   |  | 9c. COUNTY OF DEATH<br><b>Washington</b>   |  |
| 10a. STATE<br><b>Penna.</b>  |  |  |  | 10b. COUNTY<br><b>Franklin</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>12289 Ft. Loudon Rd. Mercersburg, Pa. 17236</b>            |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>12289 Ft. Loudon Rd.</b>   |  |  |  |
| 10f. ZIP CODE<br><b>17236</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br><b>White</b>                               |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Farmer &amp; Tax. Coll.</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>General Farming</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Ernst</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Dolly Hull</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Esther Ernst</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17236 12289 Ft. Loudon Rd., Mercersburg, Pa.</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Paul's Cem.</b>   |  | 20c. LOCATION — City or Town, State<br><b>Clear Spring, Wash. Co., Md.</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Linger-Fries F. Home 47 N. Park Ave., Mercersburg, Pa. 17236</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>CARDIORESPIRATORY ARREST</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>CARCINOMA OF THE PANCREAS.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  | Approximate interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                 |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |
| 29c. LICENSE NUMBER<br><b>022043</b>   |  |  |  |   |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/9/90</b>   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 26 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ESTHER C. EDELIN</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 14, 1990</b>  |  | 3. TIME OF DEATH<br><b>4:12 A. M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-46-9282</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>SEPT. 7, 1909</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>WASHINGTON, DC</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>HOLY CROSS HOSPITAL</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SILVER SPRING</b>  |  |
| 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>MONTGOMERY</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>SILVER SPRING</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>9737 MT. PISGAH ROAD</b>  |  |
| 10f. ZIP CODE<br><b>20903</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>ADMINISTRATIVE LAW ASST.</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>LAW</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>HERMAN BERGER</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>WILHELMINA GRAFF</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>WILLIAM R. EDELIN (HUSBAND)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9737 MT. PISGAH ROAD, SILVER SPRING, MARYLAND 20903</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MT. OLIVET CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>WASHINGTON, D.C.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert A. Hickey</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W., SIL. SP., MD 20901</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>HYPOVOLEMIC SHOCK</b>   |  |  |  |  |  |  |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |  |  |  |  |
| a. <b>PARALYTIC ILEUS</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| b. <b>COLONIC OBSTRUCTION</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| c. <b>SEPSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CANDIDA CYSTITIS</b><br><b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b><br><b>RESPIRATORY FAILURE</b>   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Arpan Woodward</i> M.D.  |  |  |  | 29c. LICENSE NUMBER<br><b>D 17656</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/14/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>TIPAPORN WOODWARD 5530 WISCONSIN AVE #550 CHEVY CHASE Md.</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>3/14 MAR 16 '90</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Gelia Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21202-0446  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the physician. Page 5 should be retained by the funeral director, page 3 should be retained by the funeral director, page 2 should be retained by the funeral director, page 1 should be retained by the funeral director.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be retained by the funeral director, page 3 should be retained by the funeral director, page 2 should be retained by the funeral director, page 1 should be retained by the funeral director.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>LEWIS HENRY ELLIOT II  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 11, 90  |  | 3. TIME OF DEATH<br>1:40 AM  |   |
| 4. SOCIAL SECURITY NUMBER<br>220-01-3264   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>69 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>5-30-20                                       |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>WASHINGTON COUNTY HOSPITAL   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>HAGERSTOWN, MARYLAND   |  | 9c. COUNTY OF DEATH<br>WASHINGTON  |   |
| 10a. STATE<br>MARYLAND   |  |  |  | 10b. COUNTY<br>WASHINGTON   |  | 10c. CITY, TOWN OR LOCATION<br>HAGERSTOWN  |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |   |
| 10e. STREET AND NUMBER<br>1745 PRESTON ROAD  |  |  |  | 10f. ZIP CODE<br>21740  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>usa   |   |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>CAUCASIAN              |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4 YEARS   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>SALES   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>HOTEL MANAGEMENT  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>FRANCIS T. ELLIOT   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>MARGARET CARSON  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>JOHN C. ELLIOT   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4101 WILSON AVE. BETHLEHEM, PA. 18017  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>TRINITY LUTHERAN CEMETERY  |  | 20c. LOCATION — City or Town, State<br>TANEYTOWN, MD. 21787   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>John M. Skiles  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>SKILES FUNERAL HOME 136 EAST BALTIMORE ST TANEYTOWN, MD. 21787  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>gastro intestinal bleed</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br>weeks   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Dissecting aortic aneurysm</i>  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
|  |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |  |  | 29c. LICENSE NUMBER<br>D11266   |  | 29d. DATE SIGNED (Month/Day/Year)<br>3/11/90   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>H. M. Weeks Hagerstown, Md</i>   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month/Day/Year)<br>MAR 14 90   |  |  |  | 32. REGISTRAR<br><i>[Signature]</i>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Herbert Clarence Earnshaw</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 16, 1990</b>   |  | 3. TIME OF DEATH<br><b>2:00 a.m.</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>109 - 28 - 9204</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>61</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 13, 1928</b>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Washington D.C.</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>43 Alma Street</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Laurel</b>   |   |
| 9c. COUNTY OF DEATH<br><b>Howard</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Howard</b>   |   |
| 10c. CITY, TOWN OR LOCATION<br><b>Laurel</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>43 Alma Street</b>  |   |
| 10f. ZIP CODE<br><b>20723</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1951 - 1953</b>  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4 Years</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Attorney</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Law Firm</b>  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Herbert Clarence Earnshaw, Sr.</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ann Marie Tondreau</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Patty Dean</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>115 9th Street Laurel, Maryland 20707</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Maryland State Veterans Cemetery Crownsville, Maryland</b>   |  | 20c. LOCATION — City or Town, State  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Donaldson Funeral Home P.A.<br/>313 Talbott Ave. Laurel, Maryland 20707</b>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardio respiratory Failure</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>End stage Chronic Obstructive Pulmonary Disease</b><br>c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b><br>d. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cardiac Arrhythmias</b>   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> D-DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |   |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D 24721</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/16/90</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>SYED A. SADIQ 14800, 4th St, Suite 11A, Laurel, MD 20707</b>   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>3/16/90</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><br><b>John A. Davidson-Randall</b>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |                                |  |   |
|---|--|--|--|--|--------------------------------|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Harry Edmondson</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 21 90</b>   |                                | 3. TIME OF DEATH<br><b>1304</b> M  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>219-34-0244</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br><b>56</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>07-19-33</b>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Carroll County General Hospital</b>   |                                | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Westminster</b>  |   |
| 9c. COUNTY OF DEATH<br><b>Carroll</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>  |                                | 10b. COUNTY<br><b>Carroll County</b>   |   |
| 10c. CITY, TOWN OR LOCATION<br><b>Westminster</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |                                | 10e. STREET AND NUMBER<br><b>350 Falcon Court Apartment 1A</b>   |   |
| 10f. ZIP CODE<br><b>21157</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (14 or 5 +)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Well Driller</b>  |                                | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Self-Employed</b>   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Roalnd B. Edmondson</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Margaret Edmondson Shortz</b>  |                                |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Marian L. Phenes</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>350 Falcon Court Apt. 1A Westminster, MD 21157</b>   |                                |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Lake View Cemetery</b>  |                                | 20c. LOCATION — City or Town, State<br><b>Sykesville, MD</b>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Bryan R. Halgile</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Haight Funeral Home (P.O. Box 195)<br/>Sykesville, MD 21784 (301)-795-1400</b>  |                                |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>a. Recurrent Ventricular fibrillation</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Congestive Heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. M.I.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b> |  |  |  |  |                                |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary Complete Heart Block</b>  |  |  |  |  |                                |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |  |                                |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |                                | 28b. TIME OF INJURY<br>M   |   |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |                                |  |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |                                |  |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Hageez N. Syon</b>   |                                |  |   |
| 29c. LICENSE NUMBER<br><b>D 25052</b>   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/21/90</b>  |                                |  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>H. A. SYED, 20 CROSSROADS Dr., Owings Mills, Md 21117</b>   |  |  |  |  |                                |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 26 90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John R. Randall</b>  |                                |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Margaret V Early</b>   |  |   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 16 1990</b>  |  | 3. TIME OF DEATH<br>HOURS MIN.<br><b>8 45 P</b>  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>579-28-4531</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>YRS. MONTHS DAYS<br><b>81 1 28</b>   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>1-29-1909</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>West Va.</b>                                    |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Magnolia Gardens Nursing Home</b>  |  |   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Lanham Md.</b>  |  | 9c. COUNTY OF DEATH<br><b>PG County</b>  |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Prince George's</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Glenn Dale</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |  |   |  |
| 10e. STREET AND NUMBER<br><b>12032 Augusta Drive</b>  |  |   |  | 10f. ZIP CODE<br><b>20769</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>No</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:<br><b>No</b> |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                          |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>11</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Stenographer</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Government</b>  |  |   |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Vangriff Gossett McNichols</b>  |  |   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Margaret Gavin</b>                          |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Barbara McDonald</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12032 Augusta Drive Glenn Dale Maryland 20769</b>  |  |   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | 20c. LOCATION — City or Town, State<br><b>Alexandria Virginia</b>  |  |   |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert E. Evans Pres.</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Beall-Evans Funeral Home, P.A.<br/>16000 Annapolis Road Bowie Maryland 20715</b>  |  |   |  |  |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>atherosclerotic cardiovascular disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>senile dementia</b><br><b>thrombocytosis</b>   |  |   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>HOURS MIN.<br><b>M</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Marceia Lane MD</b>   |  |   |  |  |  | 29c. LICENSE NUMBER<br><b>D26391</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>March 17 1990</b>                                    |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |   |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 23 '90</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Lelia Davidson-Randall</b>   |  |   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>THOMAS EZZELL</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 21, 1990</b>   |  | 3. TIME OF DEATH<br><b>11:35 AM</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>450 52 3386</b>  |  | 6. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>55</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>1/11/1935</b>                              |   |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Greater Laurel-Beltsville Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Laurel Maryland</b>   |  | 9c. COUNTY OF DEATH<br><b>Prince George's</b>  |   |
| 10a. STATE<br><b>Texas</b>   |  |  |  | 10b. COUNTY<br><b>Dallas</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Dallas</b>   |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |   |
| 10e. STREET AND NUMBER<br><b>6103 Hudson</b>   |  |  |  | 10f. ZIP CODE<br><b>75206</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>Yes</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: <b>No</b> |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>              |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) _____<br>College (1-4 or 5+) <b>4</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Salesman</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Newspaper</b>  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Unavailable</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Unavailable</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lawrence R. Aylwin</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6103 Hudson Dallas Texas 75206</b>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>  |  | 20c. LOCATION — City or Town, State<br><b>Alexandria Virginia</b>   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert E. Evans, Pres.</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Beall-Evans Funeral Home, P.A.<br/>16000 Annapolis Rd. Bowie Maryland 20715</b>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>respiratory failure</b>   |  |  |  |   |  |  | <b>1 hr</b>   |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |   |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Cancer of lung</b>  |  |  |  |   |  |  |   |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |   |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____ |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M _____  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Walter D. Wells, M.D.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D23743</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/22/90</b>                                |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARTIN WEITZ 1545 Broadway CT Orme Heights MD 20770</b>  |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 23 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b>  |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ANNABELLE G. FISHER</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>15</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>245 p.m.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>173-36-3307</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10-24-1911</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>PA.</b>   |  |   |  | 9. COUNTY OF DEATH<br><b>Frederick</b>  |  |   |  |
| 10. FACILITY NAME (If not institution, give street and number)<br><b>Northampton Nursing Home</b>  |  |   |  | 11. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  |   |  |
| 12. RESIDENCE OF DECEDENT  |  |   |  | 13. COUNTY OF DEATH<br><b>Frederick</b>   |  |   |  |
| 14a. STATE<br><b>PA.</b>   |  | 14b. COUNTY<br><b>Lawrence</b>  |  | 14c. CITY, TOWN OR LOCATION<br><b>Ellwood City</b>  |  | 14d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO           |  |
| 15. STREET AND NUMBER<br><b>407 Pershing Street</b>  |  |   |  | 16. ZIP CODE<br><b>16117</b>  |  | 17. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 18. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 19. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE YEAR OR DATES   |  | 20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 21. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                                |  |
| 22. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  | 23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>School teacher</b>  |  | 24. KIND OF BUSINESS/INDUSTRY<br><b>Education</b>   |  |   |  |
| 25. FATHER'S NAME (First, Middle, Last)<br><b>Frank Sanders</b>  |  |   |  | 26. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Janet Sinclair</b>  |  |   |  |
| 27. INFORMANT'S NAME (Type/Print)<br><b>Sue Gebbie</b>   |  |   |  | 28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5703 Woodlyn Rd., Frederick</b>  |  |   |  |
| 29. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 30. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Locust Grove Cemetery</b>   |  | 31. LOCATION — City or Town, State<br><b>Ellwood City, PA.</b>  |  |   |  |
| 32. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Handa L. Lemmer</b>  |  |   |  | 33. NAME AND ADDRESS OF FACILITY<br><b>Stauffer Funeral Home, 1621 Opossumtown Pike, Frederick, Md. 21701</b>   |  |   |  |
| 34. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Extensive vaginal cervical carcinoma</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>carcinoma</b><br>c. <b>carcinoma</b><br>d. <b>carcinoma</b> |  |   |  |   |  |   |  |
| 35. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>pilot ventral obstruction</b>   |  |   |  |   |  |   |  |
| 36. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 37. HOSPITAL:<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA   |  | 38. OTHER:<br><input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 39. 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 40. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 41. 25. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 42. 26a. DATE OF INJURY (Month, Day, Year)  |  | 43. 26b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO          |  |
| 44. 26c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 45. 26d. DESCRIBE HOW INJURY OCCURED  |  | 46. 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 47. 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                          |  |
| 48. 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 49. 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>  |  |   |  | 50. 29c. LICENSE NUMBER<br><b>D 14620</b>   |  | 51. 29d. DATE SIGNED (Month, Day, Year)<br><b>3/16/90</b>   |  |
| 52. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>P. Gregory Rausch, M.D., 501 W. 7th Street, Frederick, MD 21701</b>  |  |   |  |   |  |   |  |
| 53. 31. DATE FILED (Month, Day, Year)<br><b>MAR 16 1990</b>  |  |   |  | 54. 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Charles Alfred Folk  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>03 01 90  |  | 3. TIME OF DEATH<br>2305 M  |   |
| 4. SOCIAL SECURITY NUMBER<br>201-16-6235   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>61 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>06/29/1928   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Middletown, PA   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Frederick Memorial Hospital   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick  |   |
| 9c. COUNTY OF DEATH<br>Frederick   |  |  |  | RESIDENCE OF DECEDENT   |  |   |   |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Frederick   |  | 10c. CITY, TOWN OR LOCATION<br>Brunswick  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>21 West Potomac Street   |  |  |  | 10f. ZIP CODE<br>21716  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>Korean   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Lead Custodian   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Frederick County School Board   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Charles Alfred Folk, Sr.  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Annie Beatrice Bauchmoyer  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Ruth H. Folk   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>21 West Potomac Street, Brunswick, Maryland  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Middletown Cemetery  |  | 20c. LOCATION — City or Town, State<br>Middletown, Pennsylvania   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Barbara A. Williams, Funeral Dir.   |  | 22. NAME AND ADDRESS OF FACILITY<br>John T. Williams Funeral Home<br>100 Petersville Rd., Brunswick, MD 21716  |  |   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. MYOCARDIAL INFARCTION, ACUTE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. HYPERTENSION, ESSENTIAL<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>LEFT KIDNEY CARCINOMA  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO               |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Robert R R Roberts MD   |  |  |  | 29c. LICENSE NUMBER<br>D09867   |  | 29d. DATE SIGNED (Month, Day, Year)<br>03/01/90   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>RRR ROBERTS MD 15W 7th ST Frederick MD 21701-4599   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>MAR 16 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNITED STATES OF AMERICA  
DO hereby certify that  
[illegible text]

WITNESSED my hand and the seal of the  
Department of the Interior at Washington  
this [illegible] day of [illegible] 19[illegible]

001011

ITEMS:23,27 per ME G-662  
4-20-90 cm

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>CARRIE LYNN FROCK  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3-5-90  |  | 3. TIME OF DEATH<br>6:27AM M  |  |
| 4. SOCIAL SECURITY NUMBER<br>N/A   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>0 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>DEC. 13, 1989  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>FREDERICK MEMORIAL HOSPITAL  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>FREDERICK  |  | 9c. COUNTY OF DEATH<br>FREDERICK COUNTY   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 9a. STATE<br>MARYLAND  |  | 10b. COUNTY<br>FREDERICK   |  | 10c. CITY, TOWN OR LOCATION<br>THURMONT   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>128 E. MAIN ST.  |  |  |  | 10f. ZIP CODE<br>21788  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>N/A   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>N/A   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>GARY LEE FROCK, SR.   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>TAMMY SUE STELY  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>MR. & MRS. GARY LEE FROCK, SR.   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>128 E. MAIN ST., THURMONT, MD. 21788   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>HAUGH'S CEMETERY   |  | 20c. LOCATION — City or Town, State<br>LADIESBURG, MD.  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>ROBERT E. DAILEY & SON, P.A.<br>615 E. MAIN ST., THURMONT, MD. 21788  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. SUDDEN INFANT DEATH SYNDROME<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>XXX YES 2 <input type="checkbox"/> NO  |
|  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>XXX YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>XXX YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Louise D. Hall  |  |  |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-6-90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARGARITA A. KORELL, MD 111 Penn Street, Baltimore, MD 21201  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 08 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

no

90 08921

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Audrey Bernice Carroll Fichter</i>  |  |   |  | 2. DATE OF DEATH<br>MONTH <i>02</i> DAY <i>25</i> YEAR <i>90</i>   |  | 3. TIME OF DEATH<br><i>1130A</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>578-62-5559</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><i>81</i> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>2-28-1908</i>  |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><i>13030 Old Annapolis Road,</i>   |  |   |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><i>Frederick</i>  |  | 8c. COUNTY OF DEATH<br><i>Frederick</i>   |  |
| RESIDENCE OF DECEDENT  |  |   |  |  |  |   |  |
| 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Frederick</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>Frederick</i>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |
| 10e. STREET AND NUMBER<br><i>13030 Old Annapolis Road</i>  |  |   |  | 10f. ZIP CODE<br><i>21701</i>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>white</i>                            |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  |   |  | 18a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>School teacher</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>education</i>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>not known</i>  |  |   |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>not known</i>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Chuck Carlton, atty.</i>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>P. O. Box 380, Mt. Airy, Maryland 21771</i>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Arlington National Cemetery</i>                                    |  | 20c. LOCATION — City or Town, State<br><i>Arlington, Virginia</i>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Sharon Camille Cline</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>1621 Opossumtown Pike, Frederick, Maryland 21701</i>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>   |  |   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><i>M</i>   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Robert R R Roberts MD</i>  |  |   |  | 29c. LICENSE NUMBER<br><i>D09867</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>02/25/90</i>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>RRR ROBERTS MD 15 W 7th Street Frederick MD 21701-4599</i>   |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>MAR 05 1990</i>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rendell</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10/10/10

90 08922

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>RICHARD KARL FROMM</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 17, 1990</b>   |  | 3. TIME OF DEATH<br>AM PM<br><b>2:15 AM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>549-72-9436</b>  |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>40</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>APRIL 4, 1949</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>KANSAS</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>NIH, THE CLINICAL CENTER</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BETHESDA</b>  |  |
| 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |  |  |  | RESIDENCE OF DECEDENT   |  |   |  |
| 10a. STATE   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>WASHINGTON, DC</b>  |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>1611 MONROE ST., N.E.</b>   |  |  |  | 10f. ZIP CODE<br><b>20018</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><b>1</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>6</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>LOAN OFFICER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>DEPT. OF HOUSING AND URBAN DEVELOPMENT</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>WALTER J. FROMM</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>HELEN L. MYERS</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JEFFREY C. VAN LUYN</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1611 MONROE ST., NE, WASHINGTON, DC 20018</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input type="checkbox"/> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>SUBURBAN CREMATORY</b>  |  | 20c. LOCATION — City or Town, State<br><b>SILVER SPRING, MD</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Richard Papp</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>RAPP FUNERAL SERVICES, P. A.<br/>933 GIST AVE., SILVER SPRING, MD 20910</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Lymphoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. AIDS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>c.</b> DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>d.</b> DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  | Approximate interval Between Onset and Death<br><b>1 yr.</b><br><b>1 1/2 yrs</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO                                   |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>D. J. Papp</i>   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-23-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Bd 10/Rm 12N226 F. Gale</b><br><b>9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 23 '90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |   |
|--|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>COREAN FLORA</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03-21-90</b>   |  | 3. TIME OF DEATH<br><b>6:45 p.m.</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>224-30-4349</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>06-22-08</b>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>11928 Raven Rock Terrace</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Gaithersburg</b>   |   |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |  |   |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>   |   |
| 10c. CITY, TOWN OR LOCATION<br><b>Gaithersburg</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>11928 Raven Rock Terrace</b>  |   |
| 10f. ZIP CODE<br><b>20878</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th</b> College (13-16 or 17+) <b>College (13-16 or 17+)</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Burford</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Martha Miller</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Jearnice Luch (Daughter)</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11928 Raven Rock Ter., Gaithersburg, MD 20878</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Fisher Funeral Home</b>  |  | 20c. LOCATION — City or Town, State<br><b>Portsmouth, VA</b>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>George R. Snowden</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Snowden Funeral Home, P.A.<br/>Rockville, MD 20850</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Failure</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Arteriosclerotic Heart Disease</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |  | Approximate Interval Between Onset and Death<br><b>20 yrs.</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b><br><b>Sick Sinus Syndrome</b>  |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br><b>N/A</b>  |  |   |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)   |   |
| 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Michael A. Bolonese, M.D.</i>   |  | 29c. LICENSE NUMBER<br><b>D 24324</b>  |   |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>3/22/90</b>  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)<br><b>Michael A. Bolonese</b><br><b>19231 MONTGOMERY VILLAGE AVE.<br/>GAITHERSBURG, MD 20879</b>  |  | 31. DATE FILED (Month, Day, Year)<br><b>MAR 23 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Clarence Otis Ferguson  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>03 08 90  |  | 3. TIME OF DEATH<br>9:15 a <sup>m</sup>   |   |
| 4. SOCIAL SECURITY NUMBER<br>228-16-3639  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>71 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>06/14/18   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Virginia  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Greater Baltimore Medical Center  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Towson   |   |
| 9c. COUNTY OF DEATH<br>Baltimore  |  |  |  | 10a. STATE<br>MD  |  | 10b. COUNTY   |   |
| 10c. CITY, TOWN OR LOCATION<br>Gambrills  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>P.O. Box 263-540 2nd Street   |   |
| 10f. ZIP CODE<br>21054  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE YEAR OR DATES<br>1936-39 |   |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (8-12) College (1-4 or 5+)<br>12  |   |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Civil Service   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Dept. of Army   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>John B. Ferguson   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Gertrude Wingfield   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Freda M. Ferguson   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>540 2nd Street, Gambrills, MD 21054  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Meadowridge Cemetery  |  | 20c. LOCATION — City or Town, State<br>Dorsey, MD   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Thomas A. Hardesty   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Hardesty Funeral Home P.A.<br>851 Annapolis Road, Gambrills, MD   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiorespiratory Arrest<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Multiple System Failure<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. Metastatic Cancer - Colon and Bladder<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Francesco Grasso M.D.  |  |  |  | 29c. LICENSE NUMBER<br>D 38363  |  | 29d. DATE SIGNED (Month, Day, Year)<br>3/8/90   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Francesco Grasso, M.D. G.B.M.C.  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>MAR 09 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Gina M. ...  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transmission form. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ASCS 27

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FANNIE J. Ferby</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 05 90</b>   |  | 3. TIME OF DEATH<br><b>1243 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-26-5431</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>YRS. MONTHS DAYS<br><b>93 05 08</b>   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>6/14/30</b>                             |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Dorchester Ger Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cambridge</b>   |  | 9c. COUNTY OF DEATH<br><b>Dorchester</b>   |  |
| 10a. STATE<br><b>Md.</b>   |  |  |  | 10b. COUNTY<br><b>Dorchester</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Cambridge</b>                                      |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>611 Hubert ST. Cambridge, Md.</b>  |  |  |  |
| 10f. ZIP CODE<br><b>21613</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>              |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joasha Jones</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Fannie Jones</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Georgia Ann Cephas</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>611 Hubert ST. Cambridge, Md. 21613</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Waucho Ceme</b>   |  | 20c. LOCATION — City or Town, State<br><b>Cambridge, Md.</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Janella C. Henry</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Henry Funeral Home Cambridge, Md.</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lobar pneumonia</b>   |  |  |  |   |  |  |  |
| a. <b>LOBO pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| b. <b>COPD</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| c. <b>COPD</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| d. <b>COPD</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>AODM</b>  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED  |  |   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dr. Fadden</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D26388</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>03 05 90</b>                               |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Fadden Dorchester General Hospital Cambridge, MD</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR - 9 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Gelia Davidson-Randall</b>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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ITEM:6 per FH G-661

3-29-90 ja

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 08926

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>George Foster</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 01 90</b>   |  | 3. TIME OF DEATH<br><b>1:15 a.m.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>1 97-09-6771-A</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>74 73</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>08-20-16</b>                       |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>GREATER BALTIMORE MEDICAL CENTER</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>TOWSON</b>  |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>                                      |  |
| 10a. STATE<br><b>Md.</b>  |  |  |  | 10b. COUNTY<br><b>Carroll</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Hampstead</b>                              |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>4546 Lower Beckleysville Rd.</b>   |  |  |  |
| 10f. ZIP CODE<br><b>21074</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>      |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4 year</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Owner</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>International Envelope Co., PA.</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Ephriam Foster</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Christina Baird</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ruth Foster</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4546 L. Beckleysville Rd. Hampstead, Md. 21074</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Wesley Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Hampstead</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Shirley W. Eline</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Eline Funeral Home<br/>934 S. Main St., Hampstead, Md. 21074</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CARDIOPULMONARY ARREST</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. RUPTURED ABDOMINAL AORTIC ANEURYSM</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d.</b> |  |  |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Rebecca A. Ludwig</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D36226</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/1/90</b>                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Rebecca A. Ludwig; GBMC - 6701 N. Charles Street; Towson, MD 21204</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 5 - '90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Rendell</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21201-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained in the hospital or by the attending physician. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mary Catherine Fry</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 5, 1990</b>  |  | 3. TIME OF DEATH<br><b>8:40 a m</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-10-2849</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (in yrs. last birthday)<br><b>83</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>8-11-1906</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Northampton Nursing Center</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY<br><b>Frederick</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>16 Mount Olivet Blvd.</b>   |  |  |  | 10f. ZIP CODE<br><b>21701</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Albert Castle</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Anna Mary Main Biser</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>George Albert Fry</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16 Mount Olivet Blvd., Frederick, Md. 21701</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mount Olivet Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Frederick, Maryland 21701</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Richard C. C. Biser</i> MO0021   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney &amp; Basford PA Funeral Home</b><br><b>106 East Church St., Frederick, MD 21701</b>   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>Chronic heart failure</b>  |  |   |  | Approximate interval Between Onset and Death<br><b>4 months</b>  |  |
|  |  | b. <b>Strial fibrillation</b>  |  |   |  | <b>4 months</b>  |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  | c. <b>Coronary artery disease</b>  |  |   |  | <b>Several yrs.</b>  |  |
|  |  | d.   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal insufficiency</b><br><b>Massive obesity</b>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
|  |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Amur</i> MD  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Jan. 5, 1989</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Abdul Majeed, MD, 801 Tollhouse Avenue, Frederick, Maryland 21701</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 08 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-2446  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and retained for burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



*[Faint, illegible handwritten text at the bottom of the page]*

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

DHMH-1A Rev 1/89

at 0038



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Earl F. FLEISCHMAN</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Jan. 20, 1990</b>  |  | 3. TIME OF DEATH<br><b>0903</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-05-8069</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Sept. 9, 1901</b>                                  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>Rosemont Ave., Frederick, Md.</b>   |  |  |  | 10f. ZIP CODE<br><b>21701</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Animal caretaker</b>   |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>U. S. Government</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John H. Fleischman</b>   |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Caroline L. Bare</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>John F. "Jack" Fleischman</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>444 Carrollton Drive, Frederick, Md. 21701</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mount Olivet Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Frederick, Md. 21701</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Richard C. Bayard</b> M00021   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney and Basford Funeral Home</b><br><b>106 East Church St., Frederick, Md. 21701</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CONGESTIVE HEART FAILURE</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>PNEUMONIA</b><br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ATRIAL FIBRILLATION</b> |  |  |  |   |  |   | Approximate Interval Between Onset and Death |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 28g. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>James S. Griston M.D.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>021944</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/24/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>James S. Griston M.D. 1475 TANEY AVE Suite 204 Frederick Md.</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 23 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Gabe Davidson-Randall</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>William David Ferrell</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 22, 1990</b>  |  | 3. TIME OF DEATH<br><b>5:58 A.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-30-8924</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>98</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan. 9, 1892</b>                                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Brunswick</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>217 East Eight Street</b>   |  |  |  | 10f. ZIP CODE<br><b>21716</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>6</b><br>College (1-4 or 5+) <b>6</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Farmer</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Farming</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James C. Ferrell</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Laura DeLauter</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Hilda Mae Smith</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2206 Jefferson Pike, Knoxville, Md. 21758</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Jefferson Reformed Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Jefferson, Md.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Alan H. Ruby</b> M00703  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney &amp; Basford P.A. Funeral Home, 21701<br/>106 East Church Street, Frederick, Md.</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |   |  |   |  |
| a. <b>Peritonitis</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| b. <b>Sigmoid volvulus</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| c.<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| d.<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes mellitus, hypoproteinemia,<br/>seizure disorder, dementia,<br/>extreme old age</b>   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE NOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Kathleen Woods Stern MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D32073</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/22/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>610 Ninth Ave Brunswick Md 21716 K W STERN MD</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 23 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson Handall</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report

is a description of the

2.

3. The second part of the report

is a description of the

3.

4. The third part of the report

is a description of the

5. The fourth part of the report

4.

5. The fifth part of the report

is a description of the

5.

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7.

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9.

10.

8. The sixth part of the report is a description of the

9.

9. The seventh part of the report is a description of the

10.

10. The eighth part of the report is a description of the

11.

11. The ninth part of the report is a description of the

12. The tenth part of the report is a description of the



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |  |   |  |
|--|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Lawrence S. Forrest  |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>2 2 90  |  | 3. TIME OF DEATH<br>9:40 P M  |  |
| 4. SOCIAL SECURITY NUMBER<br>215-26-9010   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>60 YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br>MAY 8, 1929  |  | 8. BIRTHPLACE (State or Foreign Country)<br>PENN.   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>University Hospital (STU)  |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |  | 9c. COUNTY OF DEATH   |  |
| RESIDENCE OF DECEDENT  |  |  |   |   |  |   |  |
| 10a. STATE<br>MARYLAND   |  | 10b. COUNTY<br>FREDERICK   |   | 10c. CITY, TOWN OR LOCATION<br>SABILLASVILLE  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>15932 FOXVILLE-DEERFIELD RD.   |  |  |   | 10f. ZIP CODE<br>21780  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                                    |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7<br>College (1-4 or 5+) N/A  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>SELF EMPLOYED  |   | 16b. KIND OF BUSINESS/INDUSTRY<br>LOGGING & FIREWOOD COMP.  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>THEODORE S. FORREST   |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>LULU MAE SMITH   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>BETTY L. FORREST (WIFE)  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>15932 FOXVILLE-DEERFIELD RD.<br>SABILLASVILLE, MD. 21780   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>MT. BETHEL CEMETERY  |   | 20c. LOCATION — City or Town, State<br>FOXVILLE, MD.  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>ROBERT E. DAILEY & SON, P.A.<br>615 E. MAIN ST., THURMONT, MD. 21788  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cranio-cerebral injury</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |   |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
|  |  |  |   |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>2-2-90   |   | 28b. TIME OF INJURY<br>1:05 P M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br>Subject struck by tree  |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>Kelbough Road<br>outside (while cutting trees) (rear), Frederick Co., MD  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Mario F. Golle, Jr., M.D., Assistant  |  |  |   | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>2-3-90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Mario F. Golle, Jr., M.D., Assistant 111 Penn Street, Baltimore, MD 21201 vl  |  |  |   |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 07 1990   |  |  |   | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3, and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

**TO THE HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. **TO THE FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-18 Rev 1/89



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>MARY RUTH FEDERLINE</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>22 99 9090</i>   |  | 3. TIME OF DEATH<br><i>3:45 P.M.</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>213-28-6171</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>59 59</i> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>08-06-30</i>                                       |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>MARYLAND</i>  |  |  |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>FREDERICK MEMORIAL HOSPITAL</i>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>FREDERICK</i>   |  | 9c. COUNTY OF DEATH<br><i>FREDERICK</i>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><i>MD</i>  |  | 10b. COUNTY<br><i>FREDERICK</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>THURMONT</i>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>11020-B POWELL ROAD</i>   |  |  |  | 10f. ZIP CODE<br><i>21788</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>WHITE</i>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>11th</i><br>College (1-4 or 5+) <i>HOMEMAKER</i>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>WILLIAM A. MORTON, SR.</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>FLORENCE H. MARTIN</i>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>MELVIN M. FEDERLINE, SR.</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>11020-B POWELL RD. THURMONT, MD 21788</i>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>MT. CARMEL CEMETERY</i>   |  | 20c. LOCATION — City or Town, State<br><i>THURMONT, MD</i>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert E. Dailey</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, PA<br/>615 E. MAIN STREET THURMONT, MD 21788</i>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |   |  |   |  |
| a. <i>Cardio pulmonary Arrest</i><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| b. <i>Acute Myocardial Infarction</i><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| c. <i>Hours</i><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| d. <i>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</i>  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John Davidson</i> MD   |  |  |  | 29c. LICENSE NUMBER<br><i>D 35183</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>2/9/90</i>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Ali J. Afrookteh MD 300 W 9th St Frederick, MD</i>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>FEB 13 1990</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Bianca Morse Federico</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 14, 1990</b>   |  | 3. TIME OF DEATH<br><b>7:30 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>578-62-2472</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><b>94</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Apr. 7, 1895</b>                           |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Fernwood House</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Bethesda</b>  |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |  |
| 10a. STATE<br>---  |  |  |  | 10b. COUNTY<br>---  |  | 10c. CITY, TOWN OR LOCATION<br><b>Washington, D.C.</b>                               |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>3634 Jocelyn Street, N.W.</b>   |  |  |  | 10f. ZIP CODE<br><b>20015</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>              |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>George Hamlin Morse</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary L. Perrine</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Patricia F. Highet</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6004 Anniston Rd., Bethesda, MD 20817</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Comfort Crematory</b>   |  | 20c. LOCATION — City or Town, State<br><b>Alexandria, VA</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael D. Nelson</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Joseph Gawler's Sons, Inc.<br/>5130 Wisconsin Ave, NW, Washington, D.C.</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebralvascular accident</b>   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| b. <b>Atrial fibrillation</b>  |  |  |  |   |  |  | 1977   |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| c. <b>Atherosclerotic coronary vascular disease</b>  |  |  |  |   |  |  | 1973   |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| d.   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Previous cerebral vascular accident - 1986</b>  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>D. T. Young, M.D.</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D21544</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Mar. 15, 1990</b>                          |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>David V. Young, M.D., 4530 Connecticut Ave., N.W., Washington, D.C. 20008</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 16 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1203-3146

BALTIMORE, MD

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be used for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>NATHAN FREISHTAT</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>14</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>6 50 A.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>579-18-1993</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>March 15, 1910</b>                                    |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Russia</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Hebrew Home of Greater Washington</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Rockville</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>6105 Montrose Road</b>  |  |  |  | 10f. ZIP CODE<br><b>20852</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>12</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Food Distributor</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Wholesale</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Gershon Freishtat</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Anna Horowitz</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/print)<br><b>Harvey W. Freishtat (Son)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>85 Williston Road; Brookline, MA 02146</b>  |  |   |  |
| 20a. MANNER OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Shaarei Tfiloh Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Md.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br/>1170 Rockville Pike; Rockville, Md. 20852</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ASTROCYTOMA - GRADE IV</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>b. RENAL FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>c. SEIZURE ACTIVITY</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>d.</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
|  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
|  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Merlyn Vemury MD. PHYSICIAN</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D35791</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/15/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MERLYN VEMURY, MD. HEBREW HOME OF GREATER WASH., ROCKVILLE, MD</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 20 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 9 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1. FOR  
STATE  
REGISTRAR

REG. NO.

90 08936

| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>John E. Fitez</b>  |   |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>6</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>2:00 PM</b>   |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
|---|---|--|--|---|--|--|--|---|---|--|----------------------------|----------------------------------|--|--------------------------------|----------------------------------|--|---------------|----------------------------------|--|----|--|--|
| 4. SOCIAL SECURITY NUMBER<br><b>213-05-5645</b>   |   | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2/11/03</b>  |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |   |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Agnes Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| 9c. COUNTY OF DEATH   |   |  |  | 10a. STATE<br><b>Md.</b>  |  | 10b. COUNTY<br><b>Anne Arundel</b>   |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Hanover</b>   |   |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>7158 Forest Avenue</b>  |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| 10f. ZIP CODE<br><b>21076</b>   |   |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |   |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |  |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>   |   |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>Welder</b>   |  |  |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Welder</b>  |   |  |  | 17. KIND OF BUSINESS/INDUSTRY<br><b>Md. Shipbuilding &amp; Drydock</b>  |  |  |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| 18. FATHER'S NAME (First, Middle, Last)<br><b>Unknown Fitez</b>   |   |  |  | 19. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Unknown</b>   |  |  |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| 20. INFORMANT'S NAME (Type/Print)<br><b>Kathy D. Kamsch</b>   |   |  |  | 21. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7158 Forest Avenue, Hanover, Md. 21076</b>   |  |  |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| 22. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |  |  | 23. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Meadowridge Memorial Park</b>   |  | 24. LOCATION — City or Town, State<br><b>Elkridge, Maryland</b>  |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| 25. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |   |  |  | 26. NAME AND ADDRESS OF FACILITY<br><b>Gary L. Kaufman Funeral Homes<br/>5695 Main St., Elkridge, Md. 21227</b>   |  |  |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| 27. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><table border="1"><thead><tr><th>IMMEDIATE CAUSE (Final disease or condition resulting in death)</th><th>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</th><th>Approximate Interval Between Onset and Death</th></tr></thead><tbody><tr><td>a. <b>Pulmonary edema.</b></td><td>DUE TO (OR AS A CONSEQUENCE OF):</td><td></td></tr><tr><td>b. <b>Aspiration Pneumonia</b></td><td>DUE TO (OR AS A CONSEQUENCE OF):</td><td></td></tr><tr><td>c. <b>CVA</b></td><td>DUE TO (OR AS A CONSEQUENCE OF):</td><td></td></tr><tr><td>d.</td><td></td><td></td></tr></tbody></table> |   |  |  |   |  |  |  | IMMEDIATE CAUSE (Final disease or condition resulting in death) | Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | Approximate Interval Between Onset and Death | a. <b>Pulmonary edema.</b> | DUE TO (OR AS A CONSEQUENCE OF): |  | b. <b>Aspiration Pneumonia</b> | DUE TO (OR AS A CONSEQUENCE OF): |  | c. <b>CVA</b> | DUE TO (OR AS A CONSEQUENCE OF): |  | d. |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death)   | Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | Approximate Interval Between Onset and Death                               |  |   |  |  |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| a. <b>Pulmonary edema.</b>  | DUE TO (OR AS A CONSEQUENCE OF):  |  |  |   |  |  |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| b. <b>Aspiration Pneumonia</b>  | DUE TO (OR AS A CONSEQUENCE OF):  |  |  |   |  |  |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| c. <b>CVA</b>   | DUE TO (OR AS A CONSEQUENCE OF):  |  |  |   |  |  |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| d.  |   |  |  |   |  |  |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| 28. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal failure, rheumatic heart disease with atrial fibrillation, Hypertension.</b>   |   |  |  |   |  |  |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| 29. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |   |  |  |   |  |  |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| 30. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |   |  |  |   |  |  |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| 31. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |   |  |  | 32. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| 33. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   |  |  | 34. DATE OF INJURY (Month, Day, Year)   |  | 35. TIME OF INJURY<br>M <b>1</b> <input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| 36. DATE OF INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |   |  |  | 37. DESCRIBE NOW INJURY OCCURRED  |  |  |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| 38. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   |  |  | 39. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| 40. CERTIFIER<br>(Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |  |  |   |  |  |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| 41. SIGNATURE AND TITLE OF CERTIFIER<br><b>Erin L. M.D. Resident</b>  |   |  |  | 42. LICENSE NUMBER  |  | 43. DATE SIGNED (Month, Day, Year)<br><b>3-6-90</b>  |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| 44. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |   |  |  |   |  |  |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |
| 45. DATE FILED (Month, Day, Year)<br><b>MAR 09 '90</b>  |   |  |  | 46. REGISTRAR'S SIGNATURE<br>   |  |  |  |   |   |  |                            |                                  |  |                                |                                  |  |               |                                  |  |    |  |  |

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Q. Now, you said that you saw the car on the street in front of the house on the 14th of May, 1968, is that correct?

A. Yes, that is correct.

Q. And you saw the car on the street in front of the house on the 15th of May, 1968, is that correct?

A. Yes, that is correct.

Q. And you saw the car on the street in front of the house on the 16th of May, 1968, is that correct?

A. Yes, that is correct.

Q. And you saw the car on the street in front of the house on the 17th of May, 1968, is that correct?

A. Yes, that is correct.

Q. And you saw the car on the street in front of the house on the 18th of May, 1968, is that correct?

A. Yes, that is correct.

Q. And you saw the car on the street in front of the house on the 19th of May, 1968, is that correct?

A. Yes, that is correct.

Q. And you saw the car on the street in front of the house on the 20th of May, 1968, is that correct?

A. Yes, that is correct.

Q. And you saw the car on the street in front of the house on the 21st of May, 1968, is that correct?

A. Yes, that is correct.

Q. And you saw the car on the street in front of the house on the 22nd of May, 1968, is that correct?

A. Yes, that is correct.

Q. And you saw the car on the street in front of the house on the 23rd of May, 1968, is that correct?

A. Yes, that is correct.

Q. And you saw the car on the street in front of the house on the 24th of May, 1968, is that correct?

A. Yes, that is correct.

Q. And you saw the car on the street in front of the house on the 25th of May, 1968, is that correct?

A. Yes, that is correct.

Q. And you saw the car on the street in front of the house on the 26th of May, 1968, is that correct?

A. Yes, that is correct.

Q. And you saw the car on the street in front of the house on the 27th of May, 1968, is that correct?

A. Yes, that is correct.

90 08937

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |   |   |   |  |
|---|--|---|---|---|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Viola Ellen Fauble  |  |   |   | 2. DATE OF DEATH<br>MONTH 03 DAY 04 YEAR 90   |   | 3. TIME OF DEATH<br>1210 P M  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>219-20-2218  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br>63 YRS. |   | 7. DATE OF BIRTH (Month, Day, Year)<br>11/26/1926 |   | 8. BIRTHPLACE (State or Foreign Country)<br>Charles Town, WVA   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Frederick Memorial Hospital   |  |   |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick  |   | 9c. COUNTY OF DEATH<br>Frederick  |   |  |
| RESIDENCE OF DECEDENT   |  |   |   |   |   |   |   |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Frederick  |   | 10c. CITY, TOWN OR LOCATION<br>Knoxville  |   | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |  |
| 10e. STREET AND NUMBER<br>2314B Jefferson Pike  |  |   |   | 10f. ZIP CODE<br>21758  |   | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Housewife  |   | 16b. KIND OF BUSINESS/INDUSTRY<br>Homemaker   |   |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Arlington Albert Ayers   |  |   |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Dorothy Lenore Greaver   |   |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Edward F. Fauble  |  |   |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 115, Knoxville, MD 21758  |   |   |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Park Heights Cemetery   |   | 20c. LOCATION — City or Town, State<br>Brunswick  |   |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Barbara A. Williams, Funeral Dir.  |  | 22. NAME AND ADDRESS OF FACILITY<br>John T. Williams Funeral Home<br>100 Petersville Rd., Brunswick, MD 21716   |   |   |   |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <u>Extensive abd. carcinoma</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>Extensive ovarian carcinoma</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |   |   |   |   | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Sepsis, fistula</u>  |  |   |   |   |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |   |   |   |   |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |   |   |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |   | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |   | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |   |   |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |   |   | 29c. LICENSE NUMBER<br>0146 2C  |   | 29d. DATE SIGNED (Month, Day, Year)<br>3/4/90   |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Rausch P G MD PA, West Seventh Street, Frederick, Maryland 21701   |  |   |   |   |   |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 16 1990  |  | 32. REGISTRAR'S SIGNATURE<br>   |   |   |   |   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 08938

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>ROSA LEE FRENCH</u>   |  |  |  | 2. DATE OF DEATH<br>MONTH <u>3</u> DAY <u>1</u> YEAR <u>90</u>   |  | 3. TIME OF DEATH<br><u>1600</u> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><u>213.68.5765</u>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F         |  | 6. AGE (In yrs. last birthday)<br><u>76</u> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><u>FEB 2, 1914</u>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><u>MARYLAND</u>  |  |  |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br><u>BALTIMORE CITY</u>   |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><u>MARYLAND</u>  |  |  |  | 10b. COUNTY<br><u>HOWARD</u>   |  | 10c. CITY, TOWN OR LOCATION<br><u>ELKBRIDGE</u>  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><u>5290 LANDING ROAD</u>   |  | 10f. ZIP CODE<br><u>21227</u>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <u>WHITE</u>  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>6th grade</u><br>College (1-4 or 5+) <u>none</u>  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>HOMEMAKER</u>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>OWN HOME</u>  |  | 17. FATHER'S NAME (First, Middle, Last)<br><u>CHARLES T. WEBER</u>   |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>ALICE V. MOORE</u>   |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br><u>THOMAS A. FRENCH</u>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>SAME AS 10e</u>  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or<br><u>MEADOWRIDGE MEMORIAL PARK</u>  |  | 20c. LOCATION — City or Town, State<br><u>ELKBRIDGE, MARYLAND</u>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>John M. Brown</u>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>GARY L. KAUFMAN FUNERAL HOME</u><br><u>5695 MAIN STREET ELKBRIDGE, MD. 21227</u>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>PULMONARY ARREST</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>SMALL CELL LUNG CARCINOMA</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <u>COPD</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  | Approximate Interval Between Onset and Death<br><u>IMMEDIATE</u>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <u>1</u> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>MEDICAL RESIDENT PGY-1</u>   |  |  |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>3/1/90</u>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>JUAN HERRADA MD. ST AGNES HOSPITAL 900 CATON AVE BALTO MD 21229</u>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><u>MAR 06 '90</u>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>  |  |  |  |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. The first part of the report is a general statement of the purpose and scope of the study.

2. The second part of the report is a description of the methods used in the study.

3. The third part of the report is a description of the results of the study.

4. The fourth part of the report is a discussion of the results and their implications.

5. The fifth part of the report is a conclusion.

6. The sixth part of the report is a list of references.

7. The seventh part of the report is a list of appendices.

8. The eighth part of the report is a list of figures.

9. The ninth part of the report is a list of tables.

10. The tenth part of the report is a list of footnotes.



90 08939

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ARIEL NORMAN FULKS</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 25, 1990</b>   |  | 3. TIME OF DEATH<br><b>09:45 AM</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>215-20-4047</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Nov. 25, 1926</b>                                 |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>West Virginia</b>   |  |  |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br><b>Waldorf</b>   |  | 9c. COUNTY OF DEATH<br><b>Charles</b>   |   |
| 10a. STATE<br><b>Maryland</b>  |  |  |  |   |  |   |   |
| 10b. COUNTY<br><b>Charles</b>  |  |  |  |   |  |   |   |
| 10c. CITY, TOWN OR LOCATION<br><b>Waldorf</b>  |  |  |  |   |  |   |   |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |   |
| 10e. STREET AND NUMBER<br><b>Box 278F Hamilton Road</b>  |  |  |  |   |  |   |   |
| 10f. ZIP CODE<br><b>20601</b>  |  |  |  |   |  |   |   |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  |   |  |   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>8</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Mechanic</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Bakery Industry</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Haymond Carey Fulks</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lulla Mary Molloham</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Dorothy E. Fulks</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Box 278F Hamilton Road, Waldorf, Md. 20601</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Trinity Memorial Gardens</b>  |  | 20c. LOCATION — City or Town, State<br><b>Waldorf, Md. 20604</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Huntt Funeral Home<br/>P. O. Box 156, Waldorf, Md. 20604-0156</b>   |  |   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Colon Cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br><b>18 months</b> |  |  |  |   |  |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL:<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER:<br><input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>120352</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-26-90</b>                                       |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>HARVEY I. K4 722 8920 Woodward Rd Clinton Md</b>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 27 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



001033

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |   |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>STERLING Benjamin FAULKNER Jr.  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3-6-90   |  | 3. TIME OF DEATH<br>2:20PM M   |   |
| 4. SOCIAL SECURITY NUMBER<br>227-01-4721  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>69 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>July 22, 1920   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Virginia  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>23 Ruth Avenue   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Laurel  |   |
| 9c. COUNTY OF DEATH<br>Howard County  |  |  |  | 10a. STATE<br>Md.  |  | 10b. COUNTY<br>Howard  |   |
| 10c. CITY, TOWN OR LOCATION<br>Laurel   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>23 Ruth Avenue   |   |
| 10f. ZIP CODE<br>20723  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WW2 |   |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: white   |  |  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10<br>College (1-4 or 5+) 10  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>horse trainer   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>race track   |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Sterling Benjamin Faulkner Sr.   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Kate Dorset   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Grace L.F. Torreyson  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2419 Eccleston St. Silver Spring, Md. 20902   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Metho Crematory Inc.   |  | 20c. LOCATION — City or Town, State<br>Catonsville, Md   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James Randall</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Donaldson Funeral Home P.A.<br>313 Talbott Ave. Laurel, Md. 20707  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypertensive arteriosclerotic cardiovascular disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |  | Approximate interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Chronic obstructive pulmonary disease   |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>INSPECTION |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Frank Peretti</i>   |  |  |  | 29c. LICENSE NUMBER<br>OCME  |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-7-90  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>FRANK PERETTI, MD 111 Penn Street, Baltimore, MD 21201 VC  |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>MAR 12 '90   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Randall</i>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

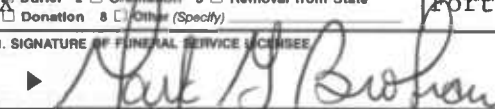
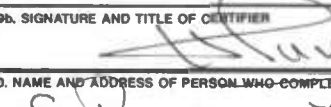
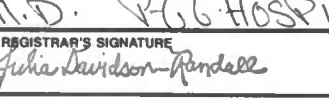
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 08941

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>THURSTON W. FUNKHOUSER</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>03</b> - DAY <b>18</b> - YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>2:45 PM</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>226-12-0030</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>1-16-21</b>  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>PRINCE GEORGES HOSPITAL CENTER</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CHEVERLY</b>  |  | 9c. COUNTY OF DEATH<br><b>PRINCE GEORGES</b>  |   |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Prince George's</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Mt. Rainier</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>3714 37th Street</b>   |  |   |  | 10f. ZIP CODE<br><b>20712</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>9th Grade</b>   |  | 15b. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Truck Driver</b>  |  | 16. KIND OF BUSINESS/INDUSTRY<br><b>Air Products &amp; Chemicals</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joseph Hickman Funkhouser</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Barb</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Wayne H. Funkhouser (Son)</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>542 Springfield Rd. Laurel, Maryland 20708</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Brentwood, Maryland</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Francis Gasch's Sons Funeral Home, P.A.<br/>4739 Baltimore Ave. Hyattsville, Md. 20781</b>   |  |   |   |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory failure</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <b>Cardioma</b> DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Bronchus</b> DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |   |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/19/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>S. V. V. J. S. J. T.D. P-66 HOSPITAL CHEVERLY MD 20785</b>  |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 23 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

14000 00

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FWING RAY GLASS</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 3, 1990</b>  |  | 3. TIME OF DEATH<br><b>2:00a</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>230-18-2186</b>  |  | 6. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>MAY 9, 1904</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>16025 OLD FREDERICK ROAD</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>EMMITSBURG,</b>   |  | 9c. COUNTY OF DEATH<br><b>FREDERICK</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>FREDERICK</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>EMMITSBURG</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>16025 OLD FREDERICK ROAD</b>  |  |  |  | 10f. ZIP CODE<br><b>21727</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>SELF EMPLOYED</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>FARMER &amp; MECHANIC</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>EMMETTE GLASS</b>  |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>SEREPTIA OSBORNE</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>RUTH KEILHOLTZ</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16025 OLD FREDERICK RD. EMMITSBURG, MD. 21727</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>KEYSVILLE UNION</b>   |  | 20c. LOCATION — City or Town, State<br><b>KEYSVILLE, MD.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John M. Skiles</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SKILES FUNERAL HOME<br/>210 W. MAIN ST., EMMITSBURG, MD. 21727</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Diffuse Poorly Differentiated Lymphocytic ~2 yrs lymphoma</b><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURED  |  |   |  |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Alan Carroll M.D.</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D18705</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>5 MARCH 1990</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ALAN CARROLL, M.D. S. SETON AVE. EMMITSBURG, MD. 21727</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 05 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HERBERT L. GLAZE Herbert L. Glaze</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>03</b> DAY <b>10</b> YEAR <b>1990</b>  |  | 3. TIME OF DEATH<br><b>5:30 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218 05 1587</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>6-5-1911</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>FREDERICK HEALTH CARE CENTER</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>FREDERICK MD</b>   |  |
| 9c. COUNTY OF DEATH<br><b>FREDERICK</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Frederick</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Mt. Airy</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>504 Hill St.</b>  |  |
| 10f. ZIP CODE<br><b>21771</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>PLUMBER/ELECTRICIAN</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Building</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>RUSSELL GLAZE</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>BERTIE KING</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Helen M. Glaze</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>504 Hill St., Mt. Airy, Md. 21771</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Prospect Cemetery</b>  |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>Mt. Airy, Md.</b>  |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Olin L. Molesworth</b>  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Olin L. Molesworth, P.A.<br/>26401 Ridge Rd., Damascus, Md. 20872</b>   |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RECURRENT CVA</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>GENERALIZED ARTERIOSCLEROSIS</b><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHF, HYPOTHYROID, RENAL INSUFF</b> |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>3-10-90</b>  |  |  |  |
| 28b. TIME OF INJURY<br><b>M</b>  |  |  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature] M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>026 999</b>   |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>3-10-90</b>  |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Ronald E. Miller, M.D. 4 Culwell Drive, Mt. Airy, Md. 21771</b>   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 13 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |                                |  |  |
|--|--|--|---|---|--------------------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Eugene Stanley GRIFFIN   |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March 15, 1990  |                                | 3. TIME OF DEATH<br>3:08 p m   |  |
| 4. SOCIAL SECURITY NUMBER<br>229-18-9698   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>70 YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Oct. 5, 1919   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Virginia   |  |  |   | 9a. FACILITY NAME (If not institution, give street and number)<br>Frederick Memorial Hospital   |                                | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick   |  |
| 9c. COUNTY OF DEATH<br>Frederick   |  |  |   | 10a. STATE<br>Maryland  |                                | 10b. COUNTY<br>Frederick   |  |
| 10c. CITY, TOWN OR LOCATION<br>Frederick   |  |  |   | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |                                | 10e. STREET AND NUMBER<br>104 West Fifth Street  |  |
| 10f. ZIP CODE<br>21701   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |                                | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>World War II  |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black   |   | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) ?  |                                | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Auto Mechanic   |  |
| 16b. KIND OF BUSINESS/INDUSTRY<br>Transportation Dept.   |  | 17. FATHER'S NAME (First, Middle, Last)<br>David H. Griffin  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Lola E. (Unknown)  |                                | 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Henrietta R. Griffin  |  |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>104 West Fifth Street, Frederick, Maryland 21701  |  | 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Fairview Cemetery   |                                | 20c. LOCATION — City or Town, State<br>Frederick, Maryland   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charles E. Hicks III</i>   |  | 22. NAME AND ADDRESS OF FACILITY<br>Charles E. Hicks III<br>106 East Church St., Frederick, MD. 21701  |   | 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. Acute cardio pulmonary arrest<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Acute arrhythmia<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. Hypertensive cardiovascular disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br>Minutes<br>Minutes<br>18 yrs. |                                | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA<br>OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |                                | 28a. DATE OF INJURY (Month, Day, Year)<br>28b. TIME OF INJURY<br>M<br>28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>28d. DESCRIBE HOW INJURY OCCURRED<br>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)          |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Ralph L. Michels, M.D.  |   | 29c. LICENSE NUMBER<br>DO 7138  |                                | 29d. DATE SIGNED (Month, Day, Year)<br>March 16, 1990  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Ralph L. Michels, MD. 801 Tollhouse Avenue, Frederick, Maryland 21701   |  |  |   |   |                                |  |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 19 1990   |  | 32. REGISTRAR'S SIGNATURE<br><i>John L. Anderson</i>   |   |   |                                |  |  |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

*Handwritten signature*

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>William E Giffin</u>   |  |   |  | 2. DATE OF DEATH<br>MONTH <u>03</u> / DAY <u>17</u> / 90 YEAR   |  |  |  | 3. TIME OF DEATH<br><u>2:50 a.m.</u>   |  |
| 4. SOCIAL SECURITY NUMBER<br><u>214-10-4150</u>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><u>74</u> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____   |  | IF UNDER 24 HRS.<br>HOURS _____ MIN. _____   |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>Feb. 28, 1916</u>  |  |   |  | 8. BIRTHPLACE (State or Foreign Country)<br><u>Maryland</u>   |  |  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><u>Washington County Hospital</u>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Hagerstown</u>  |  |  |  | 9c. COUNTY OF DEATH<br><u>Washington</u>   |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |  |  |  |  |
| 10a. STATE<br><u>Maryland</u>   |  | 10b. COUNTY<br><u>Washington</u>  |  | 10c. CITY, TOWN OR LOCATION<br><u>Hagerstown</u>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><u>916 View Street</u>  |  |   |  | 10f. ZIP CODE<br><u>21740</u>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <u>white</u>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>0-12</u> College (1-4 or 5+) _____   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>Policeman</u>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>City Gov't</u>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>William Giffin</u>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Sylvia Byrnes</u>   |  |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Mrs. Gloria Giffin</u>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>916 View Street, Hagerstown, Maryland 21740</u>   |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____   |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Rest Haven Cemetery</u>  |  |  |  | 20c. LOCATION — City or Town, State<br><u>Hagerstown, Maryland</u>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Robert Rankin</u>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><u>Minnich Funeral Home</u><br><u>415 East Wilson Blvd., Hagerstown, MD 21740</u>   |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. CARDIOGENIC SHOCK</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <u>ACUTE MYOCARDIAL INFARCTION</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <u>BACTEREMIA</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____ |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death<br><u>6 DAYS</u><br><u>6 DAYS</u><br><u>6 DAYS</u>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u><br><u>CORONARY ARTERY DISEASE</u>   |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____ |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M _____  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Pamela Fox Bradford, M.D.</u>   |  |   |  | 29c. LICENSE NUMBER<br><u>D3P892</u>  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>3/17/90</u>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>Pamela Fox Bradford, M.D. 1799 HOWELL RD. HAGERSTOWN, MD 21740</u>  |  |   |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><u>MAR 19 '90</u>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>  |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.




IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Willie Graye   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March 16, 1990   |  | 3. TIME OF DEATH<br>11:05 A M  |  |
| 4. SOCIAL SECURITY NUMBER<br>244-26-6872   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>73 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Oct. 10, 1916  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>North Carolina   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Meridian Health Care   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Silver Spring   |  |
| 9c. COUNTY OF DEATH<br>Montgomery  |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Montgomery  |  |
| 10c. CITY, TOWN OR LOCATION<br>Silver Spring   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>1110 Fidler Lane, #1112  |  |
| 10f. ZIP CODE<br>20910   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>World War II   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>2   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Clerk   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>U.S. Government  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Robert Graye  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Elizabeth Grandy   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Eric S. Graye  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1304 Monroe St. N.W., Washington, D.C. 20010  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Quantico National Cemetery   |  | 20c. LOCATION — City or Town, State<br>Triangle, Virginia  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>McGuire Funeral Service, Inc.<br>7400 Georgia Ave. N.W., Washington, D.C.  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| b. Severe Anemia<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| c. Chronic Renal Disease<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| d. Carcinoma of Prostate   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br>D557  |  | 29d. DATE SIGNED (Month, Day, Year)<br>March 16, 1990  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>R.T. Benack, M.D., 4115 Colie Drive, Wheaton, Maryland 20906  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 22 '90  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>George T. Garnett</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>03</b> DAY <b>21</b> YEAR <b>1990</b>  |  | 3. TIME OF DEATH<br><b>1054 A</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-16-2339</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>68</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>12-12-21</b>                                   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Washington Adventist Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Takoma Park</b>                                   |  |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>   |  |   |  |
| 10b. COUNTY<br><b>Montgomery</b>   |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>Takoma Park</b>   |  |   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>124 Ritchie Avenue</b>   |  |   |  |
| 10f. ZIP CODE<br><b>20912</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                     |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Plasterer</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>George Taylor</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Carrie Baylor</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary L. Garnett (wife)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>124 Ritchie Ave., Takoma Park, MD 20912</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Ash Memorial Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Sandy Spring, MD</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>George R. Snowden</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Snowden Funeral Home, P.A.<br/>Rockville, MD 20850</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary Arrest</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Advance Coronary Artery Disease and Chronic Renal Failure</b><br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE NOW INJURY OCCURRED  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>M. Karim MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D-18895</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-21-90</b>                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MOBARAK KARIM, 7610 CARROLL AVE, TAKOMA PARK, MD</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 23 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CONF NO

90 08948

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |   |  |
|--|--|--|--|--|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>DAVID CARL GOLDSTEIN   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March 23 1990  |  | 3. TIME OF DEATH<br>7:20 P.M.   |   |  |
| 4. SOCIAL SECURITY NUMBER<br>132-16-0466   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>63 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>7/14/1926  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>10708 Kings Riding Way #101  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Rockville   |  | 9c. COUNTY OF DEATH<br>Montgomery  |  |   |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Montgomery  |  | 10c. CITY, TOWN OR LOCATION<br>Rockville   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |  |
| 10e. STREET AND NUMBER<br>10708 Kings Riding Way #101  |  | 10f. ZIP CODE<br>20852   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WWII   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (14 or 5+)<br>5+   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Teacher   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Education  |  |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Simcha Goldstein  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Blanche Weissberg   |  |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Rhoda Goldstein (wife)   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10708 Kings Riding Way, #101, Rockville, MD 20852   |  |   |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>King David Memorial Garden   |  | 20c. LOCATION — City or Town, State<br>Falls Church, Virginia  |  |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Frank A. Stone</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br>1170 Rockville Pike, Rockville, MD 20852  |  |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |   | Approximate Interval Between Onset and Death  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |  |  |   |   |  |
| a. <i>Cardiomyopathy, Ischemic</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Coronary Artery Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>Atherosclerotic Heart Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.   |  |  |  |  |  |   |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |  |  |   |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28. DATE OF INJURY (Month, Day, Year)   |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Dr. John A. Galotto</i>  |  | 29c. LICENSE NUMBER<br>D11921  |  | 29d. DATE SIGNED (Month, Day, Year)<br>3/23/90  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. John A. Galotto 5225 Pooks Hill Road Bethesda, Maryland   |  |  |  |  |  |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 26 '90  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |  |  |   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used for the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90-08949

|   |  |  |  |  |  |  |   |  |  |  |  |  |  |
|---|--|--|--|--|--|--|---|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MAUDE S. GRAYBEAL</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>MAR</b> DAY <b>15</b> YEAR <b>1990</b>  |  | 3. TIME OF DEATH<br><b>10:35 P</b>                             |   |  |  |  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-18-0140</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>June 20, 1918</b> |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Delaware</b>  |  |  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>HARFORD MEMORIAL Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>HARVEY DE GRACE</b>  |  |  | 9c. COUNTY OF DEATH<br><b>HARFORD</b>   |  |  |  |  |  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Harford</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Aberdeen</b>   |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |  |  |  |  |  |
| 10e. STREET AND NUMBER<br><b>402 Clover Street</b>  |  |  |  | 10f. ZIP CODE<br><b>21001</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                 |   |  |  |  |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |  |  |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/><br><b>Three Years</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Registered Nurse</b>   |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Dover, Delaware<br/>Convalescent Home</b> |  |   |  |  |  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William C. Schwartz</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elizabeth Roe</b>  |  |  |   |  |  |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ronald W. Graybeal, Sr.</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>402 Clover St., Aberdeen, Md. 21001</b>  |  |  |   |  |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>West Nottingham Cemetery</b>  |  |  | 20c. LOCATION — City or Town, State<br><b>Colora, Maryland</b>                 |  |   |  |  |  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Ronald W. Graybeal, Sr.</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lee A. Patterson &amp; Son Funeral Home<br/>Perryville, Maryland</b>  |  |  |   |  |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>Respiratory failure</b><br><b>Sequitely ill conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b><br>a. <b>COPD</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  |   | Approximate interval Between Onset and Death   |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                          |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)                         |   | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED                          |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John D. Sun</b>  |  | 29c. LICENSE NUMBER<br><b>D12190</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/19/90</b>          |   | 29e. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)<br><b>JOHN D. SUN, HARVEY DE GRACE MD</b> |  | 31. DATE FILED (Month, Day, Year)<br><b>MAR 21 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b> |  |



90 08950

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Aiko Gales</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>19</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>19:06 P.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>577-58-8605</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>65</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2/3/25</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>JAPAN</b>   |  |   |  | 9. CITY, TOWN OR LOCATION OF DEATH<br><b>CLINTON</b>  |  | 10. COUNTY OF DEATH<br><b>P-B. County</b>  |  |
| 11. FACILITY NAME (If not institution, give street and number)<br><b>So. Maryland Hospital</b>   |  |   |  | 12. CITY, TOWN OR LOCATION OF DEATH<br><b>CLINTON</b>   |  | 13. COUNTY OF DEATH<br><b>P-B. County</b>  |  |
| 14a. STATE<br><b>MD</b>  |  | 14b. COUNTY<br><b>PRINCE GEORGES</b>  |  | 14c. CITY, TOWN OR LOCATION<br><b>MARLO HEIGHTS</b>   |  | 14d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO      |  |
| 15a. STREET AND NUMBER<br><b>3940 BEXLEY PLACE</b>   |  |   |  | 15b. ZIP CODE<br><b>20748</b>   |  | 15c. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>  |  |
| 16. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 17. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 19. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>JAPANESE</b>                            |  |
| 20. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>   |  | 21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b>   |  | 22. KIND OF BUSINESS/INDUSTRY<br><b>HOME</b>  |  |  |  |
| 23. FATHER'S NAME (First, Middle, Last)<br><b>UNK TABUCHI</b>  |  |   |  | 24. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ITO UNK</b>   |  |  |  |
| 25. INFORMANT'S NAME (Type/Print)<br><b>AKEMI TURNER</b>   |  |   |  | 26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2304 GREEN ST SE APT 204 WASH DC 20020</b>   |  |  |  |
| 27a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 27b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>WASHINGTON NATIONAL CEMETERY</b>   |  | 27c. LOCATION — City or Town, State<br><b>SUITLAND, MARYLAND</b>  |  |  |  |
| 28. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Alex S. Pope</i>   |  |   |  | 29. NAME AND ADDRESS OF FACILITY<br><b>ALEXANDER S POPE FUNERAL HOME<br/>2617 PA AVE SE WASH DC 20020</b>   |  |  |  |
| 30. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ventricular fibrillation Congestive Heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Massive Coronary Artery Atrial fibrillation</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Hypertension Multiple Brain Infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>(R) Cerebral infarction (Death)</b><br>SEQUENTIALLY LIST CONDITIONS, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |   |  |   |  |  |  |
| 31. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 32. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 33. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  |  |  |
| 34. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 35. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 36. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 37. DATE OF INJURY (Month, Day, Year)   |  | 38. TIME OF INJURY<br><b>M</b>  |  | 39. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO           |  |
| 40. DESCRIBE HOW INJURY OCCURRED   |  | 41. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 42. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 43. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |  |
| 44. SIGNATURE AND TITLE OF CERTIFIER<br><i>Julia Davidson-Randall M.D. Attending</i>   |  |   |  | 45. LICENSE NUMBER<br><b>D-24535</b>  |  | 46. DATE SIGNED (Month, Day, Year)<br><b>3/20/90</b>   |  |
| 47. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |   |  |   |  |  |  |
| 48. DATE FILED (Month, Day, Year)<br><b>MAR 22 '90</b>   |  |   |  | 49. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JEANETTA GREEN</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>03</b> DAY <b>19</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>7 50 P</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>438-20-1775</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11/10/10</b>                               |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>PRINCE GEORGE'S HOSPITAL CENTER</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CHEVERLY</b>  |  | 9c. COUNTY OF DEATH<br><b>PRINCE GEORGE'S</b>  |  |
| 10a. STATE<br><b>MARYLAND</b>  |  |   |  | 10b. COUNTY<br><b>PRINCE GEORGE'S</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>SEAT PLEASANT</b>                                  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br><b>6412 GREIG STREET</b>  |  |  |  |
| 10f. ZIP CODE<br><b>20743</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES: <b>XX</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>              |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>4</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Domestic</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>PRIVATE</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>UNKNOWN</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>LOUISIANA</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Irving Reynolds</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Lincoln Memorial Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Suitland (PG) Md.</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John E. McLean</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Plunkett Funeral Home<br/>6010 Dix St., N.E.</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Myocardial Infarction; Pulmonary Embolism</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>b. Ventricular fibrillation</b><br><b>c. Urosepsis</b><br><b>d. Hypertension</b> |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Degenerative Joint disease</b><br><b>Dermatitis</b>   |  |   |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Ram R. Tuli, MD</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>D19609</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-20-90</b>                                |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 22 '90</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. The second part of the report is a detailed description of the methods used in the study. This includes a discussion of the data sources, the sampling procedure, and the statistical methods used to analyze the data. The third part of the report is a presentation of the results of the study. This includes a discussion of the findings and their implications for the field of study. The final part of the report is a conclusion and a list of references.

2. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. The second part of the report is a detailed description of the methods used in the study. This includes a discussion of the data sources, the sampling procedure, and the statistical methods used to analyze the data. The third part of the report is a presentation of the results of the study. This includes a discussion of the findings and their implications for the field of study. The final part of the report is a conclusion and a list of references.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |  |                                |   |  |
|--|--|--|---|--|--------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Juanita Gaskins  |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March 24 1990  |                                | 3. TIME OF DEATH<br>M   |  |
| 4. SOCIAL SECURITY NUMBER<br>250-36-9422   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>70 YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>8/6/19  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>South Carolina   |  |  |   | 9a. FACILITY NAME (If not institution, give street and number)<br>Bel Forest Nursing Center  |                                | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Forest Hill  |  |
| 9c. COUNTY OF DEATH<br>Harford   |  |  |   | 10a. STATE<br>Maryland   |                                | 10b. COUNTY<br>Harford  |  |
| 10c. CITY, TOWN OR LOCATION<br>Aberdeen Proving Ground   |  |  |   | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |                                | 10e. STREET AND NUMBER<br>3807 B Veteran Court  |  |
| 10f. ZIP CODE<br>21005   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |                                | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black  |                                |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>Unknown   |  | 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker  |   | 17. KIND OF BUSINESS/INDUSTRY<br>In Home   |                                |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Early Washington  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Gertrude Hargrove   |                                |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Curtis Gaskins, Jr.  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3807 B Veteran Ct. APG, MD 21005  |                                |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>R. A. Ferris & Co.   |   | 20c. LOCATION — City or Town, State<br>West Chester, Pa.   |                                |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert M. Davis</i>  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>Larring-Cargo Funeral Home, P.A.<br>Aberdeen, Maryland 21001-3399  |                                |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>respiratory arrest</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>DUE TO (OR AS A CONSEQUENCE OF): <i>chronic obstructive pulmonary disease</i><br>DUE TO (OR AS A CONSEQUENCE OF): <i>metastatic colon CA</i> |  |  |   |  |                                |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  |                                |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |   |  |                                |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER:<br>4 <input type="checkbox"/> Nursing Home 6 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |   | 28a. DATE OF INJURY (Month, Day, Year)   |                                | 28b. TIME OF INJURY<br>M  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |   | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |                                | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |  |                                |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>David S. Dunn</i>  |  |  |   | 29c. LICENSE NUMBER<br>D32299  |                                | 29d. DATE SIGNED (Month, Day, Year)<br>3/28/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DAVID S. DUNN 2105 LAUREL BUSH Rd   |  |  |   |  |                                |   |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 27 '90  |  |  |   | 32. REGISTRAR'S SIGNATURE<br><i>Gelia Davidson-Randall</i>   |                                |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>James T. Green</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 - 23 - 90</b>   |  | 3. TIME OF DEATH<br>M<br><b>M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>172-32-5655</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>47</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>05-19-42</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>  |  |   |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br><b>Sykesville</b>  |  | 9c. COUNTY OF DEATH<br><b>Carroll County</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  |   |  | 10b. COUNTY<br><b>Carroll County</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Sykesville</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br><b>6214 Oak Hill Drive</b>  |  |   |  |
| 10f. ZIP CODE<br><b>21784</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>1</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Clerical Worker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Social Security Administration</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Jospeh H. Green</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Jane R. Zelinski</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>James T. Green, II/Jacqueline Green</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6214 Oak Hill Drive Sykesville, MD 21784</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Carroll Cremation Services</b>   |  | 20c. LOCATION — City or Town, State<br><b>Hampstead, MD</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Brian A. Haight</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Haight Funeral Home (P.O. Box 195)<br/>Sykesville, MD 21784 (301)-795-1400</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>myocardial infarction</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>coronary artery disease</b> |  |   |  |   |  | Approximate interval between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
|  |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
|  |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
|  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Hongyan Moghbeli, M.D.</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D17720</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>03-24-90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. H. Moghbeli, M.D. Bon Secours Hospital Baltimore, MD</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 28 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |  |  |   |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Giles Griffin</b>   |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-22-90</b>   |  | 3. TIME OF DEATH<br><b>1814 M</b>   |  |   |  |  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-16-4674</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>75 YRS.</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>09-12-1914</b>   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)  |  |   |  |  |  |   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Carroll County General Hospital</b> |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Westminster</b>   |  |   |  |  |  |   |  |
| 9c. COUNTY OF DEATH<br><b>Carroll County</b>   |  |  |  |   |  |  |  |   |  |   |  |  |  |   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |   |  |   |  |  |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Carroll County</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Westminster</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |  |   |  |  |  |   |  |
| 10e. STREET AND NUMBER<br><b>156 S. Center St.</b>   |  |  |  | 10f. ZIP CODE<br><b>21157</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |   |  |  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR DR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                               |  |   |  |   |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Laborer</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Construction</b>  |  |   |  |   |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Giles Griffin</b>  |  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Della Fender</b> |  |  |   |  |   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Catherine Brown Griffin</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>156 S. Center Street Westminster, MD 21157</b>  |  |  |  |   |  |   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Crestlawn Mem. Gardens</b>  |  |   |  | 20c. LOCATION — City or Town, State<br><b>Marriottsville, MD</b>   |  |   |  |   |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Brian R. Haight</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Haight Funeral Home (P.O. Box 195)<br/>Sykesville, MD 21784 (301)-795-1400</b>   |  |  |  |   |  |   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Congestive Heart Failure</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>b. Atherosclerotic Heart Disease</b><br>c. _____<br>d. _____<br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>2 week</b>   |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____<br>_____   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <b>1</b> <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                     |  |   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Chitrachedu Nagananna</b>   |  | 29c. LICENSE NUMBER<br><b>D18200</b>                       |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/22/90</b> |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>CHITRACHEDU NAGANNA 700-A poole Rd westminster MD 21157</b>  |  |  |  |   |  |  |  |   |  | 31. DATE FILED (Month, Day, Year)<br><b>MAR 26 90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Selia Davidson-Bondell</b> |  |   |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DOROTHY LUCILLE GEISENKOTTER</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>12</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>2:50 a m</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-05-1653</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birth day)<br><b>72</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>01-01-1918</b>  |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>5241 West Running Brook</b>   |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Columbia</b>  |  | 8c. COUNTY OF DEATH<br><b>Howard</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Howard</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Columbia</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>5241 West Running Brook</b>   |  |  |  | 10f. ZIP CODE<br><b>21044</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Domestic</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James Dew</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Jensine Bertelsen</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>William Paul Geisenkotter</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5241 West Running Brook, Columbia, MD 21044</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Druid Ridge Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John A. Slack</i> M00535   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Slack Funeral Home<br/>Ellicott City, Maryland 21043</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Carcinoma of lung</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>1 yr</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 25. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Charles E. Taylor</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D04345</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-12-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Charles E Taylor m 2 Knoll View Drive, Columbia md 21045</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 13 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



001037

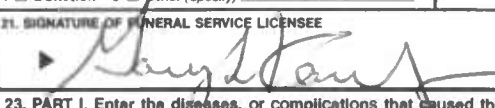
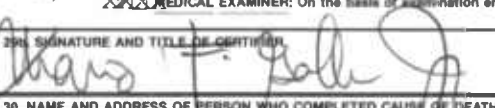

ITEMS: 23 thru 28f per ME G-662

4-11-90 cm

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1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>TIMOTHY GABBERT</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-6-90</b>   |  | 3. TIME OF DEATH<br><b>12:40PM</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>227.84.7476</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>29</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 10, 1960</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>West Virginia</b>  |  |   |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>1004 Lincoln Street</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>  |  | 9c. COUNTY OF DEATH<br><b>Washington County</b>   |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Washington</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>  |  | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                            |  |
| 10e. STREET AND NUMBER<br><b>1004 Lincoln Street</b>  |  |   |  | 10f. ZIP CODE<br><b>21740</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12th grade</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Iron Worker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Lacy Gabbert</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Goldie Baker</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. &amp; Mrs. Lacy Gabbert</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Frankfurt West Virginia</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Rosewood Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Lewisburg, W.V.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Gary L. Kaufman Funeral Homes<br/>5695 Main St. Elkridge, Maryland 21227</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>e. ACUTE METHANOL INTOXICATION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>XXX</b> YES 2 <input type="checkbox"/> NO  |  |
|   |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>XXX</b> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input checked="" type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>3-6-90</b>   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>SUBJECT INGESTED METHANOL</b>   |  |   |  |   |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>HOME</b>   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>1004 LINCOLN STREET<br/>HAGERSTOWN, WASHINGTON CO., MD</b>   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>XXX</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |   |  | 29c. LICENSE NUMBER<br><b>OCME</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-7-90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>FRANK PERETTI, MD 111 Penn Street, Baltimore, MD 21201</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 09 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general introduction to the subject of the study.

2. The second part of the report is a detailed description of the methods used in the study.

3. The third part of the report is a discussion of the results of the study.

4. The fourth part of the report is a conclusion and a list of references.

5. The fifth part of the report is a list of appendices.

6. The sixth part of the report is a list of figures.

7. The seventh part of the report is a list of tables.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ELVIN VERL GOOD</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Mar. 18, 1990</b>  |  | 3. TIME OF DEATH<br>HOURS MINUTES<br><b>10:20 PM</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>219-16-6590</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug. 10, 1910</b>   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>2000 High Point Road</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Forest Hill</b>   |  | 9c. COUNTY OF DEATH<br><b>Harford</b>   |   |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |   |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Harford</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Forest Hill</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>2000 High Point Road</b>   |  |  |  | 10f. ZIP CODE<br><b>21050</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                          |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b><br>College (1-4 or 5+) <b>College</b>  |  | 18a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Farmer</b>                   |  | 18b. KIND OF BUSINESS/INDUSTRY<br><b>Agriculture</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Kenneth Good</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Maudie Ann Morrison</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>A. Faye Good</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2000 High Point Road, Forest Hill, Md. 21050</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Bel Air Memorial Gardens</b>  |  | 20c. LOCATION — City or Town, State<br><b>Bel Air, Md.</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Howard K. McComas III</i>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Howard K. McComas III Funeral Home, P.A.<br/>1317 Cokesbury Road, Abingdon, Md. 21009</b>                 |  |   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Prostate Cancer (metastatic)</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J.K. Lynch</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>35012</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/19/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>HARFORD MEDICAL<br/>MAR'S LYNCH &amp; HASWELL<br/>620 BOULTON STREET<br/>BEL AIR, MD 21014<br/>301-838-6434</b>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 20 '90</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 08958

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |   |  |                                   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|-----------------------------------|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Lawrence (NMN) Gibbs   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3 16 90   |  |  |  | 3. TIME OF DEATH<br>1045 A. M.  |  |                                   |  |  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>402-26-8336 A   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>65 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Nov. 23, 1924                 |  | 8. BIRTHPLACE (State or Foreign Country)<br>Kentucky  |  |                                   |  |  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Rt. 26 & Rt. 32  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Eldersburg   |  |  |  | 9c. COUNTY OF DEATH<br>Carroll  |  |                                   |  |  |  |   |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |  |  |   |  |                                   |  |  |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Carroll  |  | 10c. CITY, TOWN OR LOCATION<br>New Windsor  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |                                   |  |  |  |   |  |
| 10e. STREET AND NUMBER<br>3318 Hooper Road   |  |   |  | 10f. ZIP CODE<br>21776  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |                                   |  |  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WW II |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |  |                                   |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 4 Yrs.<br>College (1-4 or 5+) None   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Construction   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |                                   |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John Gibbs  |  |   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Nancy (unknown) |  |   |  |                                   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Ruth A. Gibbs  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3318 Hooper Rd. New Windsor, Md. 21776   |  |  |  |   |  |                                   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Lakeview Memorial Park  |  |  |  | 20c. LOCATION — City or Town, State<br>Eldersburg, Maryland   |  |                                   |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL HOME<br><i>Charles B. Smith, Jr.</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Burrier Funeral Home<br>Winfield, Maryland 21784  |  |  |  |   |  |                                   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Exsanguination</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Ca of the lung @ radiation treatment</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>treatment</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |   |  |   |  |  |  |   |  |                                   |  | Approximate Interval Between Onset and Death   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  |  |   |  |                                   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <i>in Auto on Road</i> |  |  |  |   |  |                                   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  | 28d. DESCRIBE HOW INJURY OCCURRED |  |  |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |                                   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |   |  |                                   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Richard A. Jones MD</i>  |  |   |  | 29c. LICENSE NUMBER<br><i>D05905</i>  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>16 Mar-90</i>   |  |                                   |  |  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Richard A. Jones, Carroll Co. Gen. Hosp. Westminster, Maryland 21157  |  |   |  |   |  |  |  |   |  |                                   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>MAR 19 '90</i>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |   |  |                                   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 7, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. *[Handwritten signature]*



90 08959

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |   |
|---|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Kathryn Gallagher</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 13, 1990</b>   |  | 3. TIME OF DEATH<br><b>255 P.</b> M  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>176-34-6902</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MAY 26, 1906</b>                               |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>PENNSYLVANIA</b>   |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>HOLY CROSS HOSPITAL</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SILVER SPRING</b>                              |   |
| 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |  |   |  | RESIDENCE OF DECEDENT   |  |  |   |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>MONTGOMERY</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>KENSINGTON</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>3000 McCOMAS AVENUE</b>  |  |   |  | 10f. ZIP CODE<br><b>20895</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>HOMEMAKER</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHN SCANLON</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>KATHRYN (UNKNOWN)</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>KATHRYN MARTICELLO (DAUGHTER)</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7531 WEATHERBY DRIVE, ROCKVILLE, MARYLAND 20855</b>   |  |   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CALVARY CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>WEST CONSHOHOCKEN, PENNSYLVANIA</b>   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Francis J. Collins</b>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W., SIL. SP., MD 20901</b>   |  |   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ischemic bowel</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b>Severe peripheral vascular disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Chronic sigmoid volvulus</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br>d. <b>Renal insufficiency</b> |  |   |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal insufficiency</b>  |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)             |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Joseph F. Mayo, Jr MD</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>1</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/14/90</b>                                    |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JOSEPH F. MAYO, JR MD, 1811 PRINCE GEORGES, OLNEY, MD</b>   |  |   |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 16 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21216

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |  |   |   |  |   |   |
|--|--|--|---|--|---|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Patrick C. Gleason</i>  |  |  |   | 2. DATE OF DEATH<br>MONTH <i>MAR.</i> DAY <i>14</i> YEAR <i>90</i> |   |   |  | 3. TIME OF DEATH<br><i>5:42 P</i>   |   |
| 4. SOCIAL SECURITY NUMBER<br><i>577-42-5622</i>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><i>55</i> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS                                     | IF UNDER 24 HRS.<br>HOURS MIN.  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>AUG. 18, 1934</i>                              |  | 8. BIRTHPLACE (State or Foreign Country)<br><i>WASH. D.C.</i>                                   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Leland Memorial Hosp.</i>   |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Riverdale</i>            |   |   | 9c. COUNTY OF DEATH<br><i>Prince Georges</i>                                 |   |   |
| RESIDENCE OF DECEDENT  |  |  |   |  |   |   |  |   |   |
| 10a. STATE<br><i>MD.</i>   |  | 10b. COUNTY<br><i>PRINCE GEORGES</i>   |   | 10c. CITY, TOWN OR LOCATION<br><i>MT. RAINIER</i>                  |   |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><i>3401 NEWTON ST.</i>   |  |  |   | 10f. ZIP CODE<br><i>20712</i>                                      |   | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>WHITE</i>                         |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>10</i> College (1-4 or 5+) <i></i>  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>BRICK MASON</i>   |  |   | 16b. KIND OF BUSINESS/INDUSTRY<br><i>MASONRY</i>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>NICHOLAS GLEASON</i>   |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>MARGARET ROWAN</i>  |   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>FRANCES S. GLEASON</i>  |  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>SAME AS ITEM #10</i>  |   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>CHAMBERS CREMATORY</i>   |  |   | 20c. LOCATION — City or Town, State<br><i>RIVERDALE, MD.</i>                                |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>W. W. Chambers</i> M00091  |  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>W. W. CHAMBERS CO. INC., RIVERDALE, MD. 20737</i>  |   |  |   |   |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>ACUTE MYOCARDIAL DIS.</i><br>a. <i>Acute Myocardial Dis.</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |   |  |   |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>NONE</i>  |  |  |   |  |   |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
|  |  |  |   |  |   |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> MOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |   |
|  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |   |   |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |  |   |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John S. Rogers</i>   |  |  |   |  | 29c. LICENSE NUMBER<br><i>DO 9875</i>   |   | 29d. DATE SIGNED (Month, Day, Year)<br><i>March 14, 1990</i>                 |   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>JOHN S. ROGERS M.D. 1919 SEMINARY RD., SILVER SPRING, MD. 20910</i>  |  |  |   |  |   |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><i>MAR 16 '90</i>   |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

022-2 53



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WILLIAM GERBER</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 16 1990</b>  |  | 3. TIME OF DEATH<br>A M<br><b>10:59 A</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>022-16-7490</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JUNE 25 1918</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MINNESOTA</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>NATIONAL NAVAL MEDICAL CENTER</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BETHESDA</b>   |  |
| 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |  |  |  | 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>MONTGOMERY</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>GAITHERSBURG</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>427 CHRISTOPHER AVENUE, APT. 11</b>   |  |
| 10f. ZIP CODE<br><b>20879</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1939-1970</b>   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>6</b>  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>U. S. NAVY</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>DEFENSE</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>WILLIAM GERBER</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ESTHER COUS INS</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>LYNN GERBER</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>18615 GROSBEAK TERRACE, GAITHERSBURG, MD 20879</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Elmwood Cemetery</b>   |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>Birmingham, Alabama</b>  |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE #M00690<br><b>Howard D. Carson</b>  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>DeVol Funeral Home</b><br><b>10 East Deer Park Drive, Gaithersburg, MD</b>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a.<br>b.<br>c.<br>d.<br>Sequitally ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)<br><b>MAR 16 1990</b>   |  |  |  | 28b. TIME OF INJURY<br><b>M</b>   |  |  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>J. A. Butler MD</b>   |  |  |  |
| 29c. LICENSE NUMBER<br><b>0021881</b>  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>16 MAR 90</b>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J. A. BUTLER, LCDR, MC, USN</b><br><b>NATIONAL NAVAL MEDICAL CENTER</b><br><b>BETHESDA, MD 20814-5011</b>  |  |  |  | 31. DATE FILED (Month, Day, Year)<br><b>MAR 21 '90</b>  |  |  |  |
| 32. REGISTRAR'S SIGNATURE<br><b>Gelia Davidson-Randall</b>   |  |  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as a death certificate. TO THE REGISTRAR: This certificate should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |   |
|---|--|--|--|---|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Clara Margaret Garber</i> Clara Margaret Garber  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>02 19 90</i>   |  | 3. TIME OF DEATH<br><i>0225</i> M  |   |   |
| 4. SOCIAL SECURITY NUMBER<br><i>213-18-8151</i>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>79</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>June 17, 1910</i>  |   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Maryland</i>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Frederick Memorial Hospital</i>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Frederick</i>  |   |   |
| 9c. COUNTY OF DEATH<br><i>Frederick</i>   |  |  |  | 10a. STATE<br><i>Maryland</i>   |  | 10b. COUNTY<br><i>Frederick</i>  |   |   |
| 10c. CITY, TOWN OR LOCATION<br><i>Frederick</i>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><i>26 East Third Street</i>  |   |   |
| 10f. ZIP CODE<br><i>21701</i>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>White</i>   |   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>1</i>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Library</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Education</i>   |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Glenn O. Garber, Sr.</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Margaret B. Zeigler</i>   |  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>George David Garber</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>27187 Gloucester Drive, North Olmsted, Ohio 44070</i>   |  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Mount Olivet Cemetery</i>  |  | 20c. LOCATION — City or Town, State<br><i>Frederick, Maryland</i>  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Richard E. Gray</i> MO0255  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Keeney &amp; Basford P.A. Funeral Home</i><br><i>106 East Church St., Frederick, Md. 21701</i>   |  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>PNEUMONIA</i><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |   |   |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>ASPIRATION</i><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |   |   |
| c. <i>SUB ARACINOID HEMORRHAGE</i><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |   |   |
| d. <i>RUPTURED ANEURYSM</i>   |  |  |  |   |  |  |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |   |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |   |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>George I. Smith, Jr.</i> MD   |  |  |  | 29c. LICENSE NUMBER<br><i>D10587</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>2/19/90</i>  |   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>George I. Smith, Jr., MD 300 West Ninth Street, Frederick, Md. 21701</i>  |  |  |  |   |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><i>FEB 20 1990</i>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Rodell</i>  |  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LORRAINE FRANCES GARTRELL</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb. 17, 1990</b>  |  | 3. TIME OF DEATH<br><b>11:00 a<sup>m</sup></b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-24-9790</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>59</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9-2-1930</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MD.</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>809 Chadwick Circle</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |  |  |   |  |  |  |
| 10a. STATE<br><b>MD.</b>  |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>809 Chadwick Circle</b>  |  |  |  | 10f. ZIP CODE<br><b>21701</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Machine operator</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Rotorex</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Dolar M. Eyer</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Nellie V. Click</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Wanda Johnson</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Rt # Box 211 Smithsburg, Maryland 21783</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Hope Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Woodsboro, Maryland</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Sharon Conville Cline</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Stauffer Funeral Home<br/>1621 Opossumtown Pike, Frederick, Md.</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Arrest</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>Emphysema</b><br>c.<br>d.<br>Approximate Interval Between Onset and Death<br><b>20 years</b> |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Robert Scovner MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D14724</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/19/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Robert Scovner, 2803 Raleigh Road, Walkersville, Md 21793</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>1 FEB 20 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Handwritten notes and signatures at the bottom of the page.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Margaret Marie GROSS</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>9</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>5 p. M.</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>218-18-9933</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug. 31, 1907</b>                                 |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Meridian Nursing Home</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |   |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>Frederick</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>   |   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>304 Redwood Avenue</b>   |  |   |   |
| 10f. ZIP CODE<br><b>21701</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Meat Packer</b>             |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Frederick County Products</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Owen Baer</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ellen Brown</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ernest J. Swanson</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1504 West 8th Street, Frederick, Md. 21701</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Lukes Lutheran Cemetery</b>                                 |  | 20c. LOCATION — City or Town, State<br><b>Feagaville, Maryland</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Richard E. Gray</b> M00255  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney &amp; Basford P.A. Funeral Home</b><br><b>106 East Church St., Frederick, Md. 21701</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>TERMINAL METASTATIC COLON CANCER</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Arthur G. Manna, M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D-18191</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/10/90</b>                                       |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Arthur G. Manna, M.D. 187 Thomas Johnson Rd. Frederick MD 21701</b>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 12 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report

describes the general situation

and the results of the survey

conducted in the field

and the conclusions drawn

from the data collected

are presented in the following

sections of the report

and the results of the analysis

are discussed in the final

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JANICE H. GREEN</b> Janice H. GREEN   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>9</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>445 A</b> M  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>219-36-7862</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11 12 12</b>  |   |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>BROOKE GROVE NURSG. HOME</b>  |  |   |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>OLNEY</b>   |  | 8c. COUNTY OF DEATH<br><b>Mont.</b>   |   |
| 9. RESIDENCE OF DECEDENT   |  |   |  |   |  |   |   |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Montgomery</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Gaithersburg</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>8231 Hawkins Creamery Rd.</b>   |  |   |  | 10f. ZIP CODE<br><b>20882</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Teacher</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Public Schools</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Herbert Hyatt</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Beulah Souder</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Joy G. Schwab</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8221 Hawkins Creamery Rd., Gaithersburg, Md. 20882</b>                                      |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Damascus Meth. Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Damascus, Md.</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Olin L. Molesworth</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Olin L. Molesworth, P.A.<br/>26401 Ridge Rd., Damascus, Md. 20872</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Terminal Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Organic Brain Syndrome</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |   | Approximate interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |   |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature] MD.</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>D05809</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/9/90</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>2801 OLNEY SANDY SPRING RD. OLNEY MD 20832</b>   |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 10 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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... ..

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Harry Lewis GRAY</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 21, 1990</b>  |  | 3. TIME OF DEATH<br><b>7:07 A. M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>579-14-5946</b>   |  | 5. SEX<br><b>1 X M 2 F</b>  |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Feb. 3, 1920</b>                                    |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Massachusetts</b>  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>   |  |  |  |
| 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  |   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>  |  |  |  |
| 10a. STATE<br><b>Maryland</b>   |  |   |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Mount Airy</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><b>1 YES 2 X NO</b>   |  |   |  | 10e. STREET AND NUMBER<br><b>5808 Corporal Jones Court</b>   |  |  |  |
| 10f. ZIP CODE<br><b>21771</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  |
| 11. MARITAL STATUS<br><b>1 Never Married 2 X Married 3 Widowed 4 Divorced</b>   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><b>1 YES 2 NO</b><br>IF YES, GIVE WAR OR DATES<br><b>World War II</b>              |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 X NO</b> Specify:        |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                          |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Machinist</b> |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Self-Employed</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Harry C. Gray</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Katherine E. Williams</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Ruth L. Gray</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5808 Corporal Jones Court, Mt. Airy, Md. 21771</b> |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory</b>                             |  | 20c. LOCATION — City or Town, State<br><b>Smithsburg, Md.</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Alan H. Ruby M00703</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney &amp; Basford P.A. Funeral Home, 21701 106 East Church Street, Frederick, Md.</b>                        |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → End stage COPD</b><br><b>End-stage Pulmonary Fibrosis</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |  |  | Approximate interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Supraventricular Tachycardia</b><br><b>COP Pulmonary</b>   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 X NO</b>  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 X NO</b>   |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 NO</b> |  |
| 26. PLACE OF DEATH (Check only one)<br><b>HOSPITAL: 1 X Inpatient 2 ER/Outpatient 3 DOA</b><br><b>OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)</b>   |  | 27. MANNER OF DEATH<br><b>1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>       |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><b>1 YES 2 NO</b>   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                     |  |
| 29a. CERTIFIER (Check only one)<br><b>1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>   |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>James S. Grisson M.D.</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D 21944</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/21/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>James S. Grisson M.D. 1475 TANEY AVE, Suite 204, Frederick, Md. 21701</b>   |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 22 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Vada Cora Gaver</i>   |  | 2. DATE OF DEATH<br>MONTH <i>Jan.</i> DAY <i>12</i> YEAR <i>1990</i>   |  | 3. TIME OF DEATH<br><i>8:10 A M</i>   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>215-26-8669</i>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>78</i> YRS.  |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>Jan. 10, 1912</i>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><i>Maryland</i>  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Meredian Nursing Center</i>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Frederick</i>  |  | 9c. COUNTY OF DEATH<br><i>Frederick</i>   |  |
| 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Frederick</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>Myersville</i>  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><i>202 Main Street</i>   |  | 10f. ZIP CODE<br><i>21773</i>   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES <i>X</i>   |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input type="checkbox"/>  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Inspector</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Sewing Factory</i>  |  | 17. FATHER'S NAME (First, Middle, Last)<br><i>Fenton Elias Gaver</i>  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Mary Rebecca Ausherman</i>   |  | 19a. INFORMANT'S NAME (Type/Print)<br><i>C. Wayne E. Gaver</i>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>8343 Myersville Rd., Middletown, MD 21769</i>   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>St. Paul's Lutheran Cemetery</i>  |  | 20c. LOCATION — City or Town, State<br><i>Myersville, Maryland</i>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Patty L. Ricketts</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>504 Main Street<br/>Ricketts Funeral Home Myersville, MD 21773</i>  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>METASTATIC ADENOCARCINOMA of GALLBLADDER</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><i>M</i>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>James L. Roessler MD</i>   |  | 29c. LICENSE NUMBER<br><i>D20488</i>  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><i>1-12-90</i>  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>JAMES L ROESSLER MD PO BOX 17 MIDDLETOWN, MD. 21769</i>  |  | 31. DATE FILED (Month, Day, Year)<br><i>JAN 16 '90</i>  |  |
| 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

PAGES 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Emmett D. Gearhart</i>  |  |   |  | 2. DATE OF DEATH<br>MONTH <i>3</i> DAY <i>16</i> YEAR <i>90</i>   |  | 3. TIME OF DEATH<br><i>8:40 A</i>   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>203-10-5502</i>  |  | 5. SEX<br><i>1</i> <input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>68</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>6/5/1921</i>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Washington Co. Hospital</i>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Hagerstown MD</i>   |  | 9c. COUNTY OF DEATH<br><i>Washington Co</i>   |  |
| 10a. STATE<br><i>Penns.</i>  |  | 10b. COUNTY<br><i>Franklin</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>Mercersburg</i>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>13531 Harper Rd</i>   |  |   |  | 10f. ZIP CODE<br><i>17236</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>US</i>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><i>WW II</i>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>White</i>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i><br>College (1-4 or 5+) <i></i>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Leather Worker</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Tannery</i>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Dewey E. Gearhart</i>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Mary C. Sweeney</i>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Helen B. Gearhart</i>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>13531 Karper Rd., Mercersburg, Pa. 17236</i>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Welsh Run Brethren Cem.</i>  |  | 20c. LOCATION — City or Town, State<br><i>Montgomery Twp. Franklin Co., Pa.</i>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSER<br><i>J. H. Lininger</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Lininger-Fries Funeral Home<br/>47 N. Park Ave., Mercersburg, Pa. 17236</i>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cirrhosis</i><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br><i>6 years</i> |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Coronary Artery Disease</i><br><i>Chronic renal insufficiency</i>   |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Frederick J. Lininger MD</i>   |  |   |  | 29c. LICENSE NUMBER<br><i>223623</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>3/16/90</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>F. H. Kessler MD 1799 Howell Rd Hagerstown Md</i>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>MAR 26 1990</i>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Davidson-Randall</i> <i>21740</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ella Alberta GREEN</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>19</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>0120 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>340-03-4403</b>  |  | 5. SEX<br><b>1</b> <input type="checkbox"/> M <b>2</b> <input checked="" type="checkbox"/> F |  | 6. AGE (in yrs. last birthday)<br><b>81</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 14, 1908</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Illinois</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Washington County Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Washington</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Frederick</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Jefferson</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>3865 Jefferson Pike</b>  |  |
| 10f. ZIP CODE<br><b>21755</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br><b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:   |  |   |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>10</b>  |  |   |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Matt A. Mattson</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Amanda Karlsson</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. John A. Green</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3314 Carlisle Drive, Knoxville, Maryland 21758</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Ridgewood Cemetery</b>   |  |   |  |
| 20c. LOCATION — City or Town, State<br><b>Des Plaines, Illinois</b>  |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Kirk Lynn Roberson</b> MO0706   |  |   |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney &amp; Basford PA Funeral Home<br/>106 East Church St., Frederick, MD. 21701</b>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>a. Respiratory failure due to Bilateral pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Cerebrovascular episode with loss of swallowing.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dehydration</b><br><b>Diabetes, type II with hyperglycemia</b>  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  |   |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)  |  |  |  | 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide   |  |   |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br><b>M</b>   |  |   |  |
| 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>R. L. Kogler MD</b>   |  |   |  |
| 29c. LICENSE NUMBER<br><b>226579</b>   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/19/90</b>   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>R. L. Kogler MD 100 Geety Lane Keedysville, Md 21756</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 22 1990</b>  |  |  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ruth Garrert</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Jan. 18, 1990</b>  |  | 3. TIME OF DEATH<br><b>11 p. M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-74-1124</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>91</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>July 12, 1898</b>                                  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Homewood Retirement Center</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |
| 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>Carroll Parkway at Fairview Ave.</b>  |  |  |  | 10f. ZIP CODE<br><b>21701</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES <input checked="" type="checkbox"/> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>XX</b> |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Own home</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles A. Langley</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Annie E. Mc Shea</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Patricia McGee</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1403 Key Parkway, Frederick, Maryland 21701</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Rock Creek Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Wash., D.C.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Shanda L Lemmer</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>1621 Opossumtown Pike<br/>Frederick, Maryland 21701</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. <u>Pneumonia</u></b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. _____</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. _____</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d. _____</b> |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>1 week</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Atherosclerotic cardiovascular disease</b><br><b>osteoporosis</b>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28c. DESCRIBE HOW INJURY OCCURRED   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D16428</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/22/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 22 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Edward Leonard Goddard Sr.  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>03-10-90  |  | 3. TIME OF DEATH<br>M   |  |
| 4. SOCIAL SECURITY NUMBER<br>214-05-1013  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>78 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>10-07-11   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Anne Arundel Medical Center   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Annapolis  |  | 9c. COUNTY OF DEATH<br>Anne Arundel   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |
| 10a. STATE<br>MD  |  | 10b. COUNTY<br>Anne Arundel  |  | 10c. CITY, TOWN OR LOCATION<br>Riva   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br>206 Poplar Road, P.O. Box 144   |  |  |  | 10f. ZIP CODE<br>21140  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) 12<br>College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Electrician   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>U. S. N. A  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>James Edward Goddard   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Annie Elizabeth Isaacke  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Patricia Goddard  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>206 Poplar Road, Riva, MD 21140  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Glen Haven Cemetery  |  | 20c. LOCATION — City or Town, State<br>Glen Burnie, MD  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Thomas D. Hardisty   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Hardesty Funeral Home P.A.<br>12 Ridgely Avenue, Annapolis, MD  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>Gastrointestinal hemorrhage<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  | Approximate Interval Between Onset and Death<br>Brief   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
|   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
|   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |
| 29. CERTIFIER (Check only one)<br>29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>29b. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29c. SIGNATURE AND TITLE OF CERTIFIER<br>R. I. Hochman, MD  |  |  |  | 29d. LICENSE NUMBER<br>D5192  |  | 29e. DATE SIGNED (Month, Day, Year)<br>3/12/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>R. I. Hochman, MD  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 13 1990  |  | 32. REGISTRAR'S SIGNATURE<br>S. Davidson-Randall   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GIAMPIETRO, JOSEPH</b>  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>16</b> YEAR <b>1990</b>  |  | 3. TIME OF DEATH<br><b>1900 HRS.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br>---   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>YRS. MONTHS DAYS HOURS MIN.<br><b>8</b> <b>49</b> <b>3</b> <b>16</b> <b>90</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Holy Cross Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SILVER SPRING</b>  |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>FREDERICK</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Ijamsville</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>11286 Woodhaven Dr</b>  |  | 10f. ZIP CODE<br><b>21754</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>Dominic M. Giampietro</b>  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lesley Fay Case</b>  |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>Dominic M. Giampietro</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11286 Woodhaven Dr., Ijamsville, Md. 21754</b>   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Poplar Springs Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Poplar Springs, Md.</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Olin L. Molesworth</b>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Olin L. Molesworth, P.A.<br/>26407 Ridge Rd., Damascus, Md. 20872</b>   |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIOPULMONARY INSUFFICIENCY</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>SEVERE PREMATURITY AT 23 WEEKS GESTATION</b><br><br>Approximate Interval Between Onset and Death<br><b>8 hrs 49 min</b> |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Mary Lenore Keszler MD</b>   |  | 29c. LICENSE NUMBER<br><b>D28060</b>   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>3/16/90</b>  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARY LENORE KESZLER MD, 1500 FOREST GLEN RD, HOLY CROSS HOSPITAL SILVER SPRING, MD</b>   |  | 31. DATE FILED (Month, Day, Year)<br><b>MAR 19 1990</b>  |  |
| 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Giampietro, Baby Boy (Twin B)</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-16-90</b>   |  | 3. TIME OF DEATH<br><b>11<sup>00</sup> A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br>--   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>YRS. MONTHS DAYS<br><b>1 8</b>   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>3-16-90</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Holy Cross Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring,</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |  |
| 10a. STATE<br><b>md</b>   |  |  |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Ijamsville Ijamsville</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>11286 Woodhaven Dr</b>  |  | 10f. ZIP CODE<br><b>21754</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)                        |  |
| 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)  |  |  |  | 17. KIND OF BUSINESS/INDUSTRY  |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>Dominic M. Giampietro</b>  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Hesley Fay Case</b>   |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>Dominic M. Giampietro</b>   |  |  |  |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11286 Woodhaven Drive, Ijamsville, Md. 21754</b>  |  |  |  | 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  |
| 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Poplar Springs Cemetery</b>  |  |  |  | 20c. LOCATION — City or Town, State<br><b>Poplar Springs, Md.</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Olin L. Molesworth</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Olin L. Molesworth, P.A.<br/>26401 Ridge Rd., Damascus, Md. 20872</b>   |  |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Extreme prematurity (23 1/2 weeks gestation) 525 grams birthweight 1h 8min</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Marilea K Miller MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D35141</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-16-90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Marilea K Miller MD, Neonatology Department, Silver Spring, Md 2090</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 19 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

50 09373

Handwritten signature or text at the bottom right.

90 08974

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |   |  |  |  |   |  |   |  |
|---|--|---|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WALTER E GRANGER JR</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 18 1970</b>   |  |   |  | 3. TIME OF DEATH<br><b>4:00 P M</b>  |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>019-20-3132</b>   |  |   |  | 5. SEX<br><b>1 M 2 F</b>   |  | 6. AGE (In yrs. last birthday)<br><b>62 YRS.</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan. 23, 1928</b>                          |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Massachusetts</b>  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>  |  |   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |   |  |
| RESIDENCE OF DECEDENT   |  |   |  |  |  |   |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Frederick</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Brunswick</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><b>1 YES 2 NO</b>  |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>11 West "C" Street</b>   |  |   |  |  |  | 10f. ZIP CODE<br><b>21716</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>              |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>  |  |   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Engineering Consultant</b>   |  |   |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Engineering</b>                                 |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Walter Elliot Granger, Sr.</b>  |  |   |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Myrtle A. Richardson</b>  |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Jayne Nuse</b>  |  |   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11 West "C" Street, Brunswick, Maryland 21716</b> |  |  |  |   |  |   |  |
| 20a. MANNER OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory</b>  |  |   |  | 20c. LOCATION — City or Town, State<br><b>Smithsburg, Maryland</b>                   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Kathleen Woods Stern</b> M00706   |  |   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney &amp; Basford PA Funeral Home<br/>106 E. Church St., Frederick, MD. 21701</b>                           |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Metastatic carcinoma of prostate</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>5 yrs</b>  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Kathleen Woods Stern MD</b>   |  |   |  |  |  | 29c. LICENSE NUMBER<br><b>D32073</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/19/90</b>                                |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>K W STERN MD 610 NINTH AVE BRUNSWICK MD 21716</b>   |  |   |  |  |  |   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 19 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ATC 100 100

ATC 100 100

ATC 100 100



Henline, Wm

90 08975

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |                                      |   |  |   |  |                                   |  |
|---|--|--|--|--|--|---|--------------------------------------|---|--|---|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>William Ernest Henline  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3 5 90   |  | 3. TIME OF DEATH<br>1:10 A.M.                                       |                                      |   |  |   |  |                                   |  |
| 4. SOCIAL SECURITY NUMBER<br>214 - 36 - 6446  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>50 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Jan 25, 1940              |                                      | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  |                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Greater Laurel-Beltsville Hospital  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Laurel  |  |   | 9c. COUNTY OF DEATH<br>Prince George |   |  |   |  |                                   |  |
| 10a. STATE<br>Maryland  |  |  |  | 10b. COUNTY<br>Prince George   |  | 10c. CITY, TOWN OR LOCATION<br>Laurel                               |                                      | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |  |   |  |                                   |  |
| 10e. STREET AND NUMBER<br>329 Talbott Avenue  |  |  |  | 10f. ZIP CODE<br>20707   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                             |                                      |   |  |   |  |                                   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White |                                      |   |  |   |  |                                   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>College (1-4 or 5+)<br>4 Years   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Math Teacher  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Prince George County School System   |  |   |                                      |   |  |   |  |                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Charles Theodore Henline   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>E. Pauline Calhoun  |  |   |                                      |   |  |   |  |                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Charles Edward Henline, Sr.   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11137 Windsor Road Ijamsville, Maryland 21754   |  |   |                                      |   |  |   |  |                                   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Garrett Memorial Gardens   |  | 20c. LOCATION — City or Town, State<br>Oakland, Maryland   |  |   |                                      |   |  |   |  |                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Donaldson  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Donaldson Funeral Home P.A.<br>313 Talbott Ave. Laurel, Maryland 20707   |  |   |                                      |   |  |   |  |                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <u>respiratory failure</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>cancer of lung</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |   |                                      | Approximate Interval Between Onset and Death  |  |   |  |                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |   |                                      | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)                              |                                      | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Martin O. Wiltz   |  | 29c. LICENSE NUMBER<br>D23743  |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-5-90                       |                                      |   |  |   |  |                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARTIN WELTZ 1525 Greenway Dr. Greenbelt MD 20770  |  |  |  |  |  |   |                                      |   |  |   |  |                                   |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 06 '90   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |   |                                      |   |  |   |  |                                   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>John Walter Hutton</u>  |  |  |  | 2. DATE OF DEATH<br>MONTH <u>3</u> DAY <u>13</u> YEAR <u>90</u>  |  | 3. TIME OF DEATH<br><u>1407</u> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><u>220-52-2939</u>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><u>40</u> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><u>3-27-49</u>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><u>Elkton, Md.</u>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><u>Union Hospital</u>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Elkton</u>   |  |
| 9c. COUNTY OF DEATH<br><u>Cecil</u>  |  |  |  | 10a. STATE<br><u>Md.</u>   |  | 10b. COUNTY<br><u>Cecil</u>  |  |
| 10c. CITY, TOWN OR LOCATION<br><u>Elkton</u>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><u>376 River Road</u>  |  |
| 10f. ZIP CODE<br><u>21921</u>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>IF YES, GIVE YEAR OR DATES<br><u>XX</u><br><u>Vietnam</u>   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><u>n</u> <u>White</u>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u><br>College (1-4 or 5+) <u>College</u>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><u>Electrician</u>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Elkton Gas Works</u>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>Frank V. Hutton</u>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Deloise Broyles</u>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>James A. Hutton II</u>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>169 Hutton Road Elkton, Md. 21921</u>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Immac. Conception Cem.</u>  |  | 20c. LOCATION — City or Town, State<br><u>Cherry Hill, Md.</u>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>Gee Funeral Home</u><br><u>259 E. Main St., Elkton, Md. 21921</u>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>LIVER FAILURE</u>   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |  |  |  |  |
| b. <u>LAENNES'S CIRRHOSIS</u>  |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| c. <u>CHRONIC ALCOHOLISM</u>   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>ESOPHAGEAL VARICEAL BLEEDING</u><br><u>SPONTANEOUS BACTERIAL PERITONITIS</u>  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Charles F. Kelly MD ATTENDING PHYSICIAN</u>  |  |  |  | 29c. LICENSE NUMBER<br><u>D 22436</u>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>3/13/90</u>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>125 WEST 11th ST. ELKTON, MARYLAND 21921</u>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><u>MAR 15 '90</u>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><u>Jeha Davidson-Pondell</u>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Lillian E. Hudson</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>15</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>8:30 PM</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>216-46-7153A</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>86</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>8-12-03</b>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>   |  |  |  |   |  |   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Pleasant View Nsg Home</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Mt. Airy, MD</b>  |  | 9c. COUNTY OF DEATH<br><b>CARROLL</b>   |   |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Howard County</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>West Friendship</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>12855 Frederick Road</b>   |  |  |  | 10f. ZIP CODE<br><b>21794</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b><br>College (1-4 or 5+) <b></b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Domestic</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John R. Streaker</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lillian V. Moxley</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>James W. Hudson, Jr.</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12795 Rt. 144 West Friendship, MD 21794</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. View Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Marriottsville, MD</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Brian D. Haight</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Haight Funeral Home (PO Box 195)<br/>Sykesville, MD 21784 (301)-795-1400</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>G.I. bleeding acute</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Chronic brain syndrome</b> |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>asthma, colectomy years ago.</b>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |   |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Melvin J. Kordon MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D06588</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/15/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MELVIN Kordon 2000 Century Plaza Columbia MD 21044</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 19 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randell</b>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Kay Genevieve Hosfeld-Flater</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>12</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>9:25</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-34-6993</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>50</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>8/13/39</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Carroll Co. Gen. Hosp.</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Westminster</b>   |  | 9c. COUNTY OF DEATH<br><b>Carroll</b>   |  |
| 10a. STATE<br><b>Md</b>  |  | 10b. COUNTY<br><b>Carroll</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Finksburg</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |
| 10e. STREET AND NUMBER<br><b>1449 Deer Park Rd. Apt 2</b>  |  |  |  | 10f. ZIP CODE<br><b>21048</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>                               |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12</b>  |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Secretary</b>            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Sweethart Corp</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Harold Hosfeld</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Doris Sell</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lewis Flater</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1449 Deer Park Rd Finksburg Md 21048</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Carroll Cremation</b>   |  | 20c. LOCATION — City or Town, State<br><b>Hampstead, Md</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Pritts Funeral Home, Westminster, Md</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Immediate Cause (Final disease or condition resulting in death) →</b><br><b>Cardiac Arrest</b><br><b>Due to (or as a consequence of):</b><br><b>Arteriosclerotic Cardiovascular Disease</b><br><b>Due to (or as a consequence of):</b><br><b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br><b>Chronic Obstructive Pulmonary Disease &amp; Complications</b><br><b>Medication</b> |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Severe Chronic Obstructive Pulmonary Disease &amp; Complications</b><br><b>Medication</b>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  | 25. PLACE OF DEATH (Check only one)<br><b>MD's office</b>   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO           |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>205905</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/13/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 16 90</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

*[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page. The text is too light to transcribe accurately.]*



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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>GRACE T. HOMAN  |  |  |  | 2. DATE OF DEATH<br>MONTH 03 - DAY 02 - YEAR 90   |  | 3. TIME OF DEATH<br>8:20 p m   |  |
| 4. SOCIAL SECURITY NUMBER<br>212-74-3799  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>94 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>9/28/1895   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>SALISBURY NURSING HOME  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>SALISBURY  |  | 9c. COUNTY OF DEATH<br>WICOMICO  |  |
| 10a. STATE<br>Md.   |  |  |  | 10b. COUNTY<br>Wicomico   |  | 10c. CITY, TOWN OR LOCATION<br>Salisbury   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br>Civic Ave.  |  |  |  |
| 10f. ZIP CODE<br>21801  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Housewife  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Samuel S. Hunt   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Ida Richardson   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Stokes Homan  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Tilghman Rd., Salisbury, Md. 21801   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Cape Henlopen Crem.  |  | 20c. LOCATION — City or Town, State<br>Frankford, Del   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Gerald C. Bounds</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Bounds Funeral Home, Salisbury, Md.   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARDIORESPIRATORY ARREST</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b.<br>c.<br>d.<br>Approximate Interval Between Onset and Death<br>IMMEDIATE |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>LUMBOSACRAL MUSCLE PAIN</u><br><u>OBESITY</u>  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Mark Speake</i>   |  |  |  | 29c. LICENSE NUMBER<br>D36708   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3-3-90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARK SPEAKE, MD RT. 50 & CIVIC AVE. SALISBURY, MD. 21801   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 05 90  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Johanna Davidson</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FRANCES HANLEN</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>18</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>9:30A.M.</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>515-12-8252</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>95</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>MARCH 11, 1895</b>                                 |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>New York</b>  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Hebrew Home of Greater Wash.</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |   |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Montgomery</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Rockville</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>6121 Montrose Road</b>  |  |   |  | 10f. ZIP CODE<br><b>20852</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (8-12)</b>   |  | 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Israel Saperstein</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Bessie Goodman</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type, Print)<br><b>Nadine B. Gallun (grand-dtr.)</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16516 Roundabout Drive, Gaithersburg, MD 20878</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>King David Memorial Garden</b>   |  | 20c. LOCATION — City or Town, State<br><b>Falls Church, Virginia</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br/>1170 Rockville Pike, Rockville, MD 20852</b>   |  |   |  |   |   |
| 23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Alzheimer's disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> |  |   |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>osteoarthritis</b><br><b>S/P Fr. Lt. hip &amp; Prosthesis 1982.</b>   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>P. Talwar MD</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D 36552</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/18/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>PANKAJ TALWAR, 6121 Montrose Road Rockville Md. 20852.</b>   |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 20 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |   |
|---|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GARNET Howard</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>03</b> - DAY <b>18</b> - YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>10:51 A.M.</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>217-18-0436</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>07-23-18</b>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |  |  |   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>324 Lincoln Ave.</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville</b>  |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |   |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |   |   |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Rockville</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>324 Lincoln Ave.</b>   |  |  |  | 10f. ZIP CODE<br><b>20850</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: <b>Black</b> |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                             |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>b</b> College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION:<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Auto Maintenance</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Reed Brothers</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Frederick C. Howard</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Estelle Prather</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Manning Howard (Brother)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>304 Lincoln Ave., Rockville, MD 20850</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Lincoln Park Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Rockville, MD</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Snowden Funeral Home, P.A.<br/>Rockville, MD 20850</b>  |  |  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>GUN SHOT.</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
|   |  |  |  |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |   |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input checked="" type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |   |
|   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |   |
| 29. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |   |   |
| 29a. SIGNATURE AND TITLE OF CERTIFIER<br><i>John Tauber</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D08946</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-16-90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John Tauber 8218 Wisconsin Ave. Bethesda Md.</b>  |  |  |  |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 19 90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>AGNES M. HUGHES</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 14 90</b>   |  | 3. TIME OF DEATH<br><b>7:15 PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>578 16 0088A</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Oct 6, 1902</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Suburban Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Bethesda</b>  |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |
| 10a. STATE<br><b>MD.</b>  |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Bethesda</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>4400 East West Highway</b>   |  |  |  | 10f. ZIP CODE<br><b>20814</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>12</b><br>College (1-4 or 5+) <b>College (1-4 or 5+)</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>At Home</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Faherty</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Richard A. Hughes</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17502 Aquasco Rd. Brandywine MD. 20613</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mount Olivet Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Washington, D.C.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Richard A. Hughes</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>TAKOMA FUNERAL HOME, INC.<br/>254 Carroll St. N.W. Washington DC</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <b>Cardiopulmonary arrest.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Cerebrovascular accident acute.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Atherosclerosis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>Sudden</b><br><b>Sudden</b><br><b>old.</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>L. Aebi, MD.</b>   |  | 29c. LICENSE NUMBER<br><b>D31319</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-14-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Loreto S. Aebi, MD 8218 Wisconsin Ave #105</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 19 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randell</b>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be obtained from the State Department of Health and Mental Hygiene for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |   |  |  |
|---|--|---|--|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROBERT C. HAILE</b>  |  |   | 2. DATE OF DEATH<br>MONTH <b>03</b> DAY <b>17</b> YEAR <b>90</b> |   | 3. TIME OF DEATH<br><b>07:15A</b>           |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>577-28-3998</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.  |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>09 19 18</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SUBURBAN HOSPITAL</b>  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BETHESDA</b>           |   |   | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>MONTGOMERY</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>CHEVY CHASE</b>   |   | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>8209 KERRY RD</b>  |  |   | 10f. ZIP CODE<br><b>20815</b>                                    |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input checked="" type="checkbox"/> 5+  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>PHYSICIAN</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Medicine</b>   |   |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Haile</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elizabeth Callahan</b>  |   |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lucele B. Haile</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same As Item # 10</b>   |   |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Olivet Cem.</b>  |  | 20c. LOCATION — City or Town, State<br><b>Wash., DC</b>   |   |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Michael E. Trehon</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Joseph Gawler's Sons, Inc.<br/>5130 WI Ave. NW Wash., DC 20016</b>   |   |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MYOCARDIAL INFARCTION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |   | Approximate Interval Between Onset and Death<br><b>ACUTE</b><br><b>INDEF</b><br><b>INDEF</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|   |  |   |  |   |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>03 17 90</b>   |  | 28b. TIME OF INJURY<br><b>0645M</b>   |   | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>COLLAPSED AT HOME</b>   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>HOMER</b>  |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>SEE #10</b>   |  |
| 29. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |   |  |  |
| 29a. SIGNATURE AND TITLE OF CERTIFIER<br><b>Francis C. Mayle</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>D07099</b>  |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>03/17/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>FRANCIS C MAYLE 8200 WISCONSIN AVE BETHESDA MD 20814</b>  |  |   |  |   |   |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 20 '90</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |   |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21211

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be procured within 24 hours after death. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be filed with the funeral-transit permit, Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Hellen Gertrude Hobbs</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH <i>2</i> DAY <i>1</i> YEAR <i>1990</i>   |  | 3. TIME OF DEATH<br><i>4:20 A</i> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>218-22-8540</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>74</i> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>7-13-1915</i>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Maryland</i>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Springfield Hospital Center</i>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Sykesville</i>   |  |
| 9c. COUNTY OF DEATH<br><i>Carroll</i>  |  |  |  | 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Carroll</i>  |  |
| 10c. CITY, TOWN OR LOCATION<br><i>Mount Airy</i>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><i>104 East Church St.</i>   |  |
| 10f. ZIP CODE<br><i>21771</i>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><i>12th grade</i>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Beautician</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Beauty Shop</i>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Joseph Houff (Joseph Houff)</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Harry Smith (Ida May Smith)</i>  |  |  |  |
| 19a. INFORMANT'S NAME (Type-Print)<br><i>R. Delaine Hobbs</i>  |  |  |  | 19b. MAILING ADDRESS (Street, P.O. Number or Rural Route Number, City or Town, State, Zip Code)<br><i>205 N. Main St., Mt. Airy, Md. 21771</i>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Pine Grove Cemetery</i>   |  | 20c. LOCATION — City or Town, State<br><i>Mt. Airy, Md.</i>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Olin L. Molesworth</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Olin L. Molesworth, P.A.<br/>26401 Ridge Rd., Damascus, Md. 20872</i>   |  |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pneumonia</i><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><i>Arteriosclerotic Cardiovascular Disease</i><br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate interval Between Onset and Death<br><i>Days</i><br><i>Years</i> |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Primary Degenerative Dementia, Senile onset,<br/>Alzheimer's type</i>   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> NO   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Suha Ozgun, M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br><i>D12480</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>2-1-1990</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Suha Ozgun, M.D. Springfield Hospital Center, Sykesville, Md. 21784</i>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>FEB 02 1990</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1

be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 08985

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Charles I. Hahn</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb. 22, 1990</b>  |  | 3. TIME OF DEATH<br>H M<br><b>8:30 A.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-01-5431</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Dec. 27, 1907</b>                                  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>207 E. Ridgeville Blvd.</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Mt. Airy</b>  |  | 9c. COUNTY OF DEATH<br><b>Carroll</b>   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Carroll</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Mt. Airy</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>207 E. Ridgeville Blvd.</b>   |  |  |  | 10f. ZIP CODE<br><b>21771</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>W.W. 2</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Partner</b>                                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Automobile Agency</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles S. Hahn</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Alverta Mae Smith</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Laura Elizabeth Hahn</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>207 E. Ridgeville Blvd., Mt. Airy, Md. 21771</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Pine Grove Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Mt. Airy, Md.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Olin L. Molesworth</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Olin L. Molesworth, P.A.<br/>26401 Ridge Rd., Damascus, Md. 20872</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>K. Barakat</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D 21648</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/23/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Kusay Barakat, M.D. 310 W 9th St., Frederick, Md. 21701</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 26 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rodale</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Sister Rose Marie Heaney</u>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><u>February 19, 1990</u>   |  | 3. TIME OF DEATH<br><u>2:47 p M</u>   |  |
| 4. SOCIAL SECURITY NUMBER<br><u>216-54-8524</u>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><u>97</u> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>Feb. 10, 1893</u>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><u>Villa St. Michael</u>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Emmitsburg</u>   |  | 9c. COUNTY OF DEATH<br><u>Frederick</u>   |  |
| 10a. STATE<br><u>MD</u>   |  |  |  | 10b. COUNTY<br><u>Frederick</u>  |  | 10c. CITY, TOWN OR LOCATION<br><u>Emmitsburg</u>  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><u>333 S. Seton Ave.</u>   |  |   |  |
| 10f. ZIP CODE<br><u>21727</u>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <u>White</u>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><u>College 5+</u>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>Teacher</u>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Daughters of Charity</u>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>Francis Leo Heaney</u>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Elizabeth Julia Somers</u>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Sister Rosa Daly</u>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>333 S. Seton Ave., Emmitsburg, MD 21727</u>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>St. Joseph's</u>  |  | 20c. LOCATION — City or Town, State<br><u>Emmitsburg, MD 21727</u>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>John M. Skiles</u>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>Skiles Funeral Home, Emmitsburg, MD</u>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Congestive Heart Failure acute and chronic</u><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF): <u>Atherosclerotic Heart Disease</u><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Diabetes Mellitus</u>  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Alan Carroll MD</u>   |  | 29c. LICENSE NUMBER<br><u>D18705</u>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>20 February 90</u>   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>Alan Carroll, M.D., S. Seton Ave. Emmitsburg, MD. 21727</u>   |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><u>FEB 26 1990</u>   |  | 32. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>  |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text, possibly a signature or name, appearing in the center of the page.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>William M. Hardy</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>10</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>8:45 A.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>705-12-3570</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>92</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>11/22/1897</b>                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Health Care Center</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Brunswick</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>24 West "I" Street</b>  |  |  |  | 10f. ZIP CODE<br><b>21716</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 6</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Clerk</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>B&amp;O Railroad</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Clarence Columbus Hardy</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Fannie Gertrude Dykes</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Benjamin H. Hardy</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1452 Heatheridge Ct., Frederick, MD 21701</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Resthaven Memorial Gardens</b>  |  | 20c. LOCATION — City or Town, State<br><b>Frederick, MD</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Barbara A. Williams, Funeral Dir.</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>John T. Williams Funeral Home<br/>100 Petersville Rd., Brunswick, MD 21716</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><br>Approximate Interval Between Onset and Death<br><b>3 DAYS</b> |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Wayne M. Alford MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>016675</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/10/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>WAYNE ALFORD, BRUNSWICK, MD 21716</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 12 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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70000 00

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Margaret Louise HACKEY</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb. 5, 1990</b>   |  |  |  | 3. TIME OF DEATH<br><b>2:30 AM</b>  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-30-3662</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>March 17, 1920</b> |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Meridian Nursing Home</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |  |  |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY<br><b>Frederick</b>   |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>   |  |  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>400 North Avenue</b>   |  |  |  | 10f. ZIP CODE<br><b>21701</b>   |  |  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>  |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) _____   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>   |  |  |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>George Washington Carroll</b>   |  |  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Maggie Cornelia Proctor</b>  |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>Virginia N. Carroll</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17 Orndorff Drive, Brunswick, Md. 21716</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____                                  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Hopeline Cemetery</b>  |  |  |  | 20c. LOCATION — City or Town, State<br><b>Frederick, Md.</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Richard E. Gray</b> M00255   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hicks Funeral Home</b><br><b>1922 Forest Drive, Annapolis, Md. 21401</b>   |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiorespiratory Arrest</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>— SEPSIS</b><br><b>— Intracardiac Thrombus</b><br><b>— Cerebrovascular Accident</b> |  |  |  |
| 24. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  |  |  | 28b. TIME OF INJURY<br><b>M</b>   |  |  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dr. Julio Menocal</b>   |  |  |  |
| 29c. LICENSE NUMBER<br><b>D31916</b>   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>02-07-90</b>  |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Julio Menocal Parkview Medical Center, Frederick, Md. 21701</b>   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 07 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>   |  |  |  | 33. REGISTRAR'S NAME (Type, Print)<br><b>John Davidson</b>  |  |  |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GEORGE WARREN HARDING</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>21</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>3:45 P M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>214-42-2620</b>  |  | 6. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Nov. 27, 1904</b>                                     |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Wilson Health Care Center</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Gaithersburg</b>  |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |   |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Germantown</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>22525 Wildcat Rd.</b>   |  |  |  | 10f. ZIP CODE<br><b>20876</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b><br>College (1-4 or 5+) <b>11</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Horticulture Maintenance</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Government</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Damon Warren Harding</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Estella Lydia Wood</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Kay H. White</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>22529 Wildcat Road, Germantown, Md. 20876</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium, Inc.</b>  |  | 20c. LOCATION — City or Town, State<br><b>Bethesda, Md.</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Olin L. Molesworth</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Olin L. Molesworth, P.A.</b><br><b>26401 Ridge Rd., Damascus, Md. 20872</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Adenocarcinoma metastatic to brain</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Adenocarcinoma of the lung</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>2 months</b><br><b>UNKNOWN</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Depression</b>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)          |   |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Cheryl Winchell</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D14555</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/22/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Cheryl Winchell, MD 19241 Montgomery Village Ave, Gaithersburg Md 20879</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 23 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LUDIE HATFIELD Madonna</b>   |  |  |  | 2. DATE OF DEATH (Month, Day, Year)<br><b>03/10/90</b>  |  | 3. TIME OF DEATH<br><b>11:35 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-05-4942</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9/21/1907</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>DORCHESTER GENERAL HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CAMBRIDGE MD</b>  |  | 9c. COUNTY OF DEATH<br><b>DOR</b>   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Dorchester</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Cambridge</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>Bonnie Brook Road</b>  |  |  |  | 10f. ZIP CODE<br><b>21613</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 8</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Hughes</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Annie Brittingham</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Betty Lou Turner</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 978 Cambridge, Md. 21613</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Old Trinity Churchyard</b>  |  | 20c. LOCATION — City or Town, State<br><b>Church Creek, Md.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Thomas Funeral Home<br/>700 Locust St. Cambridge, Md. 21613</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. STROKE</b><br><b>Stroke</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
|   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide   |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>N/A</b>   |  | 28b. TIME OF INJURY<br><b>N/A</b> M   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|   |  | 28d. DESCRIBE NOW INJURY OCCURRED<br><b>N/A</b>  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>N/A</b>  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>N/A</b>      |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Ann Robinson Wilke, M.D.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D1124</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3.11.90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Ann Robinson Wilke MD</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 13 '90</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |                                |   |  |
|---|--|--|--|---|--------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WALTER E HARBOLD</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>03</b> DAY <b>08</b> YEAR <b>90</b>  |                                | 3. TIME OF DEATH<br><b>7:15 A.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>193-24-0628</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>62</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan. 8, 1928</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>FALSTON GENERAL HOSP</b>   |                                | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>FALSTON</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Harford</b>   |  |  |  |   |                                |   |  |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>Harford</b>   |                                | 10c. CITY, TOWN OR LOCATION<br><b>Joppa</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |                                |   |  |
| 10e. STREET AND NUMBER<br><b>2407 Gilwood Drive</b>   |  |  |  | 10f. ZIP CODE<br><b>21085</b>   |                                | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life)<br><b>General Manager</b>                              |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Lumber</b>   |                                |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Ervin Levin Harbold</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mabel — Guyce</b>   |                                |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Peggy A. Gerety</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>111 Ballantrae Drive, Elkton, Md. 21921</b>   |                                |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Union Chapel U. Methodist Cemetery, Joppa, Md.</b>              |  | 20c. LOCATION — City or Town, State   |                                |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Howard K. McComas III</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Howard K. McComas III Funeral Home, P.A.<br/>1317 Cokesbury Road, Abingdon, Md. 21009</b>  |                                |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebral aneurysm</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Stroke</b><br><b>HTN</b><br><b>BCU?</b> |  |  |  |   |                                | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Myocardial infarction</b>  |  |  |  |   |                                | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
|   |  |  |  |   |                                | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | HOSPITAL:<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA                          |  | 26. PLACE OF DEATH (Check only one)<br>OTHER:<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                              |                                |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |                                | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |                                |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  | 29c. LICENSE NUMBER<br><b>D-16444</b>   |                                | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/1</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |  |   |                                |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 09 90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |                                |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be filed with the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Colleen H. Hunter   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>1-4-90  |  | 3. TIME OF DEATH<br>8:00AM M  |  |
| 4. SOCIAL SECURITY NUMBER<br>192-42-5867  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>40 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Sept. 2, 1949   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Clopper & Waring House Road   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Germantown   |  | 9c. COUNTY OF DEATH<br>Montgomery County  |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |   |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Frederick  |  | 10c. CITY, TOWN OR LOCATION<br>Ijamsville   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>2006 Fire Tower Lane  |  |   |  | 10f. ZIP CODE<br>21754  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (4-5+)<br>4   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Teacher                            |  | 16b. KIND OF BUSINESS/INDUSTRY<br>High School   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Joseph R. Houk   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Anne Marie Dietrich  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>William P. Hunter, Jr.  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2006 Fire Tower Lane, Ijamsville, Md. 21754  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mount Olivet Cemetery   |  | 20c. LOCATION — City or Town, State<br>Frederick, Md.   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Olin L. Molesworth   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Olin L. Molesworth, P.A.<br>26401 Ridge Rd., Damascus, Md. 20872  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple injuries   |  |   |  |   |  |   |  |
| e. DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |  |
| f. DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |  |
| g. DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |  |
| h. DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |  |
| 24. WAS AN AUTOPSY PERFORMED?<br>xxx YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>xxxxx YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>xxx YES 2 <input type="checkbox"/> NO   |  |   |  |   |  |   |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE  |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>xxxixxixxident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br>1-4-90   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE NOW INJURY OCCURRED<br>Driver in auto/auto impact   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>Road  |  |   |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>Montgomery County, MD<br>Clopper Road & Waring Station Rd.  |  |   |  |   |  |   |  |
| 29. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>xxx MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |  |
| 29a. SIGNATURE AND TITLE OF CERTIFIER<br>Mario E. Colle, Jr. MD   |  |   |  | 29b. LICENSE NUMBER<br>OCME   |  | 29c. DATE SIGNED (Month, Day, Year)<br>1-5-90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Mario E. Colle, Jr. MD 111 Penn Street, Baltimore, MD 21201  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>JAN 05 1990  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 08993

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |  |   |  |
|--|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>George Dwaine HALL   |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>JAN 1 90  |  | 3. TIME OF DEATH<br>4:15 P M  |  |
| 4. SOCIAL SECURITY NUMBER<br>245-05-1980   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 5. AGE (In yrs. last birthday)<br>80 YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br>Nov. 18, 1909  |  | 8. BIRTHPLACE (State or Foreign Country)<br>North Carolina  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Frederick Memorial Hospital  |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick  |  | 9c. COUNTY OF DEATH<br>Frederick  |  |
| RESIDENCE OF DECEDENT  |  |  |   |   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Frederick   |   | 10c. CITY, TOWN OR LOCATION<br>Frederick  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>6817 Mountaindale Road   |  |  |   | 10f. ZIP CODE<br>21701  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+) 5  |  | 18a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Construction worker   |   | 18b. KIND OF BUSINESS/INDUSTRY<br>Road construction   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>William Hall  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Bouditch  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Georgia Hall  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6817 Mountaindale Road, Frederick, Md. 21701   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Resurrection Memorial Gardens  |   | 20c. LOCATION — City or Town, State<br>Frederick, Maryland  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Richard P.C. Buford M00021  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>Keeney and Basford Funeral Home<br>106 East Church St., Frederick, Md. 21701  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |   |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |   |   |  |   |  |
| a. Cardio-respiratory arrest   |  |  |   |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |   |   |  |   |  |
| b. Terminal malignant Lymphoma Primary in the Stomach  |  |  |   |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |   |   |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |   |   |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |   |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |   |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |   |   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |   |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide  |  | 25a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |   |   |  |   |  |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>C. M. Mawdsley  |  |  |   | 29c. LICENSE NUMBER<br>D-18191  |  | 29d. DATE SIGNED (Month, Day, Year)<br>1-2-87   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Arthur G. Mawdsley, Jr. 187 Thomas Johnson Dr. Frederick MD. 21701  |  |  |   |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>JAN 3 1990  |  |  |   | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 08994

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br>RAYMOND ALONZA HUMERICK   |  |  |  | 2. DATE OF DEATH<br>MONTH 01 DAY 16 YEAR 90   |  | 3. TIME OF DEATH<br>1200 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>705-10-5937  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>83 YRS.   |  | 7. DATE OF BIRTH<br>Feb. 8, 1906   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Frederick Memorial Hospital   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick  |  | 9c. COUNTY OF DEATH<br>Frederick   |  |
| RESIDENCE OF DECEASED   |  |  |  |   |  |  |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Frederick   |  | 10c. CITY, TOWN OR LOCATION<br>Thurmont   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br>1 Locust Drive  |  |  |  | 10f. ZIP CODE<br>21788  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. DECEASED'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>7th Grade  |  | 16a. DECEASED'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Rail Road                   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Hubert A. Humerick   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Laura M. Kipe  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Claude S. Humrick   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>112 Dogwood Ave. Thurmont, Maryland 21788  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Blue Ridge Cemetery  |  | 20c. LOCATION — City or Town, State<br>Thurmont, Maryland   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert E. Dailey</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.<br>615 EAST MAIN STREET THURMONT, MD. 21788  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Likely Metastatic Adenocarcinoma of Colon</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death<br>Months   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Urinary Tract Infection</u>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J. L. Krantz MD</i>   |  |  |  | 29c. LICENSE NUMBER<br>D35152   |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/16/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>J. L. Krantz MD 100 S. Center St Thurmont, MD 21701  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>JAN 19 1990  |  |  |  |   |  |  |  |
| REGISTRAR'S SIGNATURE<br><i>John Davidson-Hopkins</i>   |  |  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. It also mentions the scope of the study and the methods used.

2. The second part of the report is a detailed description of the experimental work. It includes a description of the apparatus used, the procedure followed, and the results obtained. It also discusses the errors and the limitations of the experiment.

3. The third part of the report is a discussion of the results. It compares the results with the theoretical predictions and with the results of other experiments. It also discusses the implications of the results and the conclusions drawn from them.

Handwritten signature and date at the bottom of the page.



90 08995

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Elizabeth Virginia HICKMAN   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>01 25 90  |  | 3. TIME OF DEATH<br>2350 P M  |  |
| 4. SOCIAL SECURITY NUMBER<br>212-62-4349   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>81 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Feb. 9, 1908   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Frederick Memorial Hospital  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick  |  | 9c. COUNTY OF DEATH<br>Frederick  |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Frederick  |  | 10c. CITY, TOWN OR LOCATION<br>Woodsboro  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br>9902 Woodsboro Road  |  |   |  | 10f. ZIP CODE<br>21798  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 College (1-4 or 5 +)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>William P. Ranneberger  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Edith Jane Specht  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Margaret R. Mohler  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9902 Woodsboro Road, Woodsboro, Maryland 21798   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mount Olivet Cemetery   |  | 20c. LOCATION — City or Town, State<br>Frederick, Maryland  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John Henry Robinson</i> MO0706   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Keeney & Basford PA Funeral Home<br>106 E. Church Street, Frederick, MD 21701   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Macrocytic Anemia</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. _____ DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____ DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____ |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Chronic Obstructive Pulmonary Disease</u>   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
|  |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John L. Pasierb MD</i>   |  |   |  | 29c. LICENSE NUMBER<br>D35553   |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/26/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>John L. Pasierb 610 9th Ave. Brunswick, MD 21716  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>JAN 29 1990   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 08996

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Julia Anne HAMMOND</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 7, 1990</b>  |  | 3. TIME OF DEATH<br><b>1:30 P. M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-05-7999</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Nov. 7, 1901</b>                                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Citizens Nursing Home of Fred. Co.</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>103 East Second Street</b>   |  |  |  | 10f. ZIP CODE<br><b>21701</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 9</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Supervisor</b>           |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Telephone Company</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John D. Hammond</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Julia A. Simpson</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Dorothy J. DeGrange</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7822 Spout Spring Rd., Frederick, Md. 21701</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Olivet Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Frederick, Maryland</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert C. C. Basford</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney and Basford Funeral Home<br/>106 East Church St., Frederick, Md. 21701</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive heart failure</b><br><br>Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>a. <b>ASHD</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>b.<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>d.<br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>COPD</b>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Thomas E. Stone</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D11012</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1-9-90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Thomas E. Stone, M.D., 4 West Third St., Frederick, Md. 21701</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 11 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rendell</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21201-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

James M. Smith

James M. Smith

90 08997

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mary Condon HODGSON</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 25, 1990</b>   |  | 3. TIME OF DEATH<br><b>5:40p M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-30-8931</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>86</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>July 4, 1903</b>                           |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Northampton Manor Nursing Center</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  |   |  | 10b. COUNTY<br><b>Frederick</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>                                      |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>302 Dill Avenue</b>   |  |   |  | 10f. ZIP CODE<br><b>21701</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>              |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) College (1-4 or 5+)<br><b>4</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Tabacconist</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Wholesale</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Albert Wilson Condon</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Fannie E. Fout</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Albertine H. Baker</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>302 Dill Avenue, Frederick, Maryland 21701</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mount Olivet Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Frederick, Maryland</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Keith Hymon Robinson</i> M00706  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney &amp; Basford PA Funeral Home</b><br><b>106 E. Church St., Frederick, MD. 21701</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>Compensatory heart failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate Interval Between Onset and Death |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>A. Austin Pearre Jr.</i>   |  |   |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/27/90</b>                                |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Austin A. Pearre, Jr., MD, 300 West Ninth Street, Frederick, Maryland 21701</b>  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 29 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>John L. ...</i>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21246

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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90 08998

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Anna M. Helman</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Jan. 11 1990</b>   |  | 3. TIME OF DEATH<br><b>12:01 p.m.</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>198-22-7575</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 4, 1908</b>   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Washington County Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>  |  | 9c. COUNTY OF DEATH<br><b>Washington</b>  |   |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |   |
| 10a. STATE<br><b>Penna.</b>   |  | 10b. COUNTY<br><b>Franklin</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Chambersburg</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>5196 Wayne Rd.</b>   |  |  |  | 10f. ZIP CODE<br><b>17201</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Peter C. Ott</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Bertha Leshner</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Clyde A. Helman Jr.</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5911 Sheller Rd., Chambersburg, PA 17201</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Grindstone Hill Cemetery</b>  |  | 20c. LOCATION — City or Town, State <b>PA</b><br><b>Guilford Twp., Franklin Co.</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Grove Funeral Home, Inc.</b><br><b>50 S. Broad St., Waynesboro, PA, 17268</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Coronary Heart Failure</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>Ischemic Heart Disease</b><br>c. <b></b><br>d. <b></b> |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dilated Peripheral Vascular Disease</b>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|   |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br><b>D21457</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/11/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ABDUL WATHERD, MD - 1610 - OAK HILL AVE. HAGERSTOWN, MD</b>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 12 90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>William Lawrence Hopkins</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 2, 1990</b>  |  | 3. TIME OF DEATH<br>M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-24-1030</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>July 22, 1909</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Union Hospital of Elkton</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Elkton</b>  |  | 9c. COUNTY OF DEATH<br><b>Cecil</b>   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Kent</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Galena</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>Box 96</b>  |  |   |  | 10f. ZIP CODE<br><b>21635</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>7</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Laborer</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>MD State Hwy Adm.</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William J. Hopkins</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Margaret McMullen</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Anna Hopkins</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>same as above</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Bethel Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Chesapeake City, MD</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Mary B. Fellows</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Fellows Funeral Home<br/>368 W. Cypress St. Millington, MD 21651</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Adenocarcinoma of Stomach</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Aspiration Pneumonia</b><br><b>ASCVD</b> |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>month</b>  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Robert Denton III</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>A30291</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/6/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Robert Denton III Box 415 Cecilton MD 21913</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 07 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |  |   |  |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |                                  |   |  |   |  |   |    |                                  |                                       |  |    |                                  |                                    |              |    |                                  |                    |              |
|--|----------------------------------|---|--|---|--|---|----|----------------------------------|---------------------------------------|--|----|----------------------------------|------------------------------------|--------------|----|----------------------------------|--------------------|--------------|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>CHARLES HENRIETTE</b>   |                                  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 24 90</b>   |  | 3. TIME OF DEATH<br><b>7:40 p M</b>   |    |                                  |                                       |  |    |                                  |                                    |              |    |                                  |                    |              |
| 4. SOCIAL SECURITY NUMBER<br><b>548-84-6795</b>  |                                  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Feb. 10, 1926</b>                                 |    |                                  |                                       |  |    |                                  |                                    |              |    |                                  |                    |              |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>MONTGOMERY GENERAL HOSPITAL</b>   |                                  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>OLNEY</b>   |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |    |                                  |                                       |  |    |                                  |                                    |              |    |                                  |                    |              |
| 10a. STATE<br><b>Maryland</b>  |                                  |   |  | 10b. COUNTY<br><b>Howard</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Mt. Airy</b>  |    |                                  |                                       |  |    |                                  |                                    |              |    |                                  |                    |              |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |                                  |   |  |   |  |   |    |                                  |                                       |  |    |                                  |                                    |              |    |                                  |                    |              |
| 10e. STREET AND NUMBER<br><b>804 Bennett Road</b>  |                                  |   |  | 10f. ZIP CODE<br><b>21771</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>Belgium</b>   |    |                                  |                                       |  |    |                                  |                                    |              |    |                                  |                    |              |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |                                  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                  |    |                                  |                                       |  |    |                                  |                                    |              |    |                                  |                    |              |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>   |                                  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Consulting Engineer</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Satellites</b>   |  |   |    |                                  |                                       |  |    |                                  |                                    |              |    |                                  |                    |              |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles A. Henriette</b>   |                                  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Adrienne Mean</b>   |  |   |    |                                  |                                       |  |    |                                  |                                    |              |    |                                  |                    |              |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Colette M. Henriette</b>  |                                  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>804 Bennett Road, Mt. Airy, Md. 21771</b>   |  |   |    |                                  |                                       |  |    |                                  |                                    |              |    |                                  |                    |              |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                                  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Pine Grove Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Mt. Airy, Md.</b>   |  |   |    |                                  |                                       |  |    |                                  |                                    |              |    |                                  |                    |              |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Olin L. Molesworth</i>   |                                  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Olin L. Molesworth, P.A.<br/>26401 Ridge Rd., Damascus, Md. 20872</b>  |  |   |    |                                  |                                       |  |    |                                  |                                    |              |    |                                  |                    |              |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Failure</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><table border="0"> <tr> <td>a.</td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td><b>Bilateral Vocal Cord Paralysis</b></td> <td>Approximate Interval Between Onset and Death<br/><b>3 mo.</b></td> </tr> <tr> <td>b.</td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td><b>Superior Vena Cava Syndrome</b></td> <td><b>6 mo.</b></td> </tr> <tr> <td>c.</td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td><b>Lung Cancer</b></td> <td><b>1 yr.</b></td> </tr> </table> |                                  |   |  |   |  |   | a. | DUE TO (OR AS A CONSEQUENCE OF): | <b>Bilateral Vocal Cord Paralysis</b> | Approximate Interval Between Onset and Death<br><b>3 mo.</b> | b. | DUE TO (OR AS A CONSEQUENCE OF): | <b>Superior Vena Cava Syndrome</b> | <b>6 mo.</b> | c. | DUE TO (OR AS A CONSEQUENCE OF): | <b>Lung Cancer</b> | <b>1 yr.</b> |
| a.   | DUE TO (OR AS A CONSEQUENCE OF): | <b>Bilateral Vocal Cord Paralysis</b>   | Approximate Interval Between Onset and Death<br><b>3 mo.</b> |   |  |   |    |                                  |                                       |  |    |                                  |                                    |              |    |                                  |                    |              |
| b.   | DUE TO (OR AS A CONSEQUENCE OF): | <b>Superior Vena Cava Syndrome</b>  | <b>6 mo.</b>   |   |  |   |    |                                  |                                       |  |    |                                  |                                    |              |    |                                  |                    |              |
| c.   | DUE TO (OR AS A CONSEQUENCE OF): | <b>Lung Cancer</b>  | <b>1 yr.</b>   |   |  |   |    |                                  |                                       |  |    |                                  |                                    |              |    |                                  |                    |              |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Obstructive Lung Disease</b>  |                                  |   |  |   |  |   |    |                                  |                                       |  |    |                                  |                                    |              |    |                                  |                    |              |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |                                  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |    |                                  |                                       |  |    |                                  |                                    |              |    |                                  |                    |              |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |                                  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |    |                                  |                                       |  |    |                                  |                                    |              |    |                                  |                    |              |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |                                  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |    |                                  |                                       |  |    |                                  |                                    |              |    |                                  |                    |              |
| 28d. DESCRIBE HOW INJURY OCCURRED  |                                  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |    |                                  |                                       |  |    |                                  |                                    |              |    |                                  |                    |              |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |                                  |   |  |   |  |   |    |                                  |                                       |  |    |                                  |                                    |              |    |                                  |                    |              |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Frank J. Mayo, MD</i>  |                                  |   |  | 29c. LICENSE NUMBER<br><b>023630</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1-25-90</b>                                       |    |                                  |                                       |  |    |                                  |                                    |              |    |                                  |                    |              |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Frank J. Mayo, MD 16220 Frederick Rd. #213, Gaithersburg, MD</b>   |                                  |   |  |   |  |   |    |                                  |                                       |  |    |                                  |                                    |              |    |                                  |                    |              |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 26 1990</b>  |                                  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |    |                                  |                                       |  |    |                                  |                                    |              |    |                                  |                    |              |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CONFIDENTIAL